BEAUFORT COUNTY SCHOOL DISTRICT
2900 Mink Point Boulevard Beaufort, SC 29901
www.beaufortschools.net

Updated 9/2021

MEDICAL HOMEBOUND PHYSICIAN AUTHORIZATION FORM

Dear Physician:

Thank you for your dedication in keeping students in South Carolina healthy and progressing academically and socially in the regular school environment to the extent that is appropriate. The below named student and his/her parent/legal guardian, or surrogate parent has requested that the school district provide medical homebound instruction due to the student's inability to come to school as a result of an illness or accident, even with the aid of transportation. A district representative may contact you to discuss strategies to maintain the student in the school environment and to request additional information. The district superintendent or his/her designee must approve any student participating in a program for medical homebound instruction or hospitalized instruction. **Please return this form to the fax number listed**.

SECTION I – STUDENT INFORMATION: (To be completed by school district personnel).

Student's Name:	Date of Birth:	Age:	Grade:
School: School Fax Number:	School Year: **2021-2022**	Is this a student with a disability? ☐ Yes ☐ No Category of disability:_____ Does the student have: ☐ IEP ☐ 504 Plan	
Name of Parent/ Guardian:			
Mailing Address of Parent/ Guardian:			

SECTION II – MEDICAL INFORMATION: (To be completed by a licensed physician, nurse practitioner, in compliance with the requirements of the Nurse Practice Act, or physician assistant in compliance with the requirements of Article 7 of the Medical Practice Act)

Diagnosis or condition that **prevents** school attendance: (Attach additional information if needed) **Form will not be accepted if not completed.**

Prognosis and Treatment: (Please include details, i.e. medication, counseling schedule, etc., concerning your plans for returning the student to school) (Attach additional information if needed)

How does this medical condition impact educational performance and access to the student's educational program? (Attached additional information if needed)

Per South Carolina Department of Education guidelines, if a mental health diagnosis indicates that long-term medical homebound instruction will be necessary, the District will advise the parent to make arrangements with a licensed mental health care professional to develop and submit a treatment plan and strategy for re-entry into the school setting. **Form will not be accepted if not completed.**

Mark one of two options below. Only (1) option should be selected.

☐ I certify that the above student needs to be placed on **Intermittent Medical Homebound. The student is required to attend school a minimum of fifty percent (50%) of the time when placed on intermittent medical homebound (non-compliance can result in unexcused absence or revocation of homebound services). Subject to a 45-day review at the administrator's discretion.**

☐ I certify that the above student cannot attend school because of illness or accident, even with the aid of transportation but may profit from instruction given in the home or hospital as of this date. **(Requests may not exceed 90 days. If the student is unable to return after 90 days, a new form must be submitted) *subject to 45-day review.**

Form will not be accepted, if this section is not complete.

Beginning Date of Nonattendance:____/____/_____ **Projected Return Date:**____/____/_____

(Undetermined or indefinite dates are not acceptable. Requests may not exceed 90 days. If the student is unable to return after 90 days, a new form must be submitted. Dates should not be prior to the first day of school and must end on the last day of school of the current school year.)

Medical Office Name:_____ Date: ____/____/_____

Physician Name:_____ Physician's Signature:_____

*To be completed by a licensed physician, nurse practitioner, in compliance with the requirements of the Nurse Practice Act, or physician assistant in compliance with the requirements of Article 7 of the Medical Practice Act

Address: _____ Phone Number: _____

SECTION III – RELEASE: (To be completed by parent/guardian or student if eighteen years or older)

I authorize the release of medical, educational, and/or mental health information to school officials.

Signature of Parent/Guardian: _____ Date: ____/____/_____

SECTION IV – AUTHORIZATION: (To be signed and dated by the District Superintendent or Designee.)

I certify that school officials will consider whether the student now qualifies under Section 504 of the Rehabilitation Act of 1973 or is eligible for entry into programs for children with disabilities. I further certify if this is a student with a disability in accordance with State Board of Education regulations and if the student's medical homebound placement constitutes a change of placement, an IEP committee with parental involvement will develop and individualized education program (IEP). Medical homebound services are authorized to begin on or after date: ___/___/_____

{ } Approved { } Denied (denial letter sent to parent) _____ Date: ____/____/_____

Signature of Superintendent or Designee

The need for medical homebound instruction may be reviewed periodically. School districts must retain this document on file for a period of five (5) years in accordance with procedures set forth in the South Carolina Pupil Accounting System Instruction Manual.

BEAUFORT COUNTY SCHOOL DISTRICT
2900 Mink Point Boulevard Beaufort, SC 29901
www.beaufortschools.net

Updated 9/2021

PARENT EXPECTATIONS FOR MEDICAL HOMEBOUND SERVICES

SECTION I – STUDENT INFORMATION: (To be completed by school district personnel).

Student's Name:	Date of Birth:	Age:	Grade:
School: School: Fax Number:	School Year: 2021-2022	Is this student classified as disabled: ☐ Yes ☐ No Area of disability:_____ Does the student have: ☐ IEP ☐ 504 Plan	
Name of Parent/ Guardian:			
Mailing Address of Parent/ Guardian:			

SECTION II – PARENT/GUARDIAN EXPECTATIONS: Please read carefully and complete with signature and date.

- I understand that eligibility is based on SC State Board of Education Regulation 43-241 and that the physician's statement is one (1) part of the information used to determine eligibility.
- I understand that my child must be enrolled in Beaufort County Schools prior to consideration for medical homebound services.
- I understand that Beaufort County Schools medical homebound personnel may contact the licensed physician to obtain information needed to determine if my child will be eligible for medical homebound services and/or if accommodations/ modifications can be made to allow the student to attend school.
- I understand that medical homebound services are for students who **cannot attend school** due to a mental or physical condition, due to an accident, an illness, or complications from pregnancy.
- I understand that if the school/district receives information that indicates a change in circumstances/eligibility during the term of my child's medical homebound placement (i.e. the student is employed, the student is no longer medically confined to the home, etc.) that a review of my child's medical homebound eligibility may be conducted by District Coordinator of Homebound Services and that my child may be subject to dismissal from medical homebound services to return to school.
- I understand that if my child is found eligible for **Intermittent Medical Homebound** services, she/he may come in and out of medical homebound instruction when ill. The District **requires the student to attend school a minimum of fifty percent (50%) of the time when placed on intermittent medical homebound**. **(Non-compliance can result in documentation as an unexcused absence or revocation of homebound services).**
- I understand long term requests or requests involving a mental health condition are subject to a forty-five (45) day renewal and/or review by the District Review Team. **A letter will be sent regarding the 45-day renewal period**.
- I understand that homebound instruction is temporary therefore, requests should not be in excess of 90 days. An extension of services may be requested; however, this request must be documented on an updated Medical Homebound Physician Authorization Form from the student's attending physician. **I understand that it is my responsibility to obtain the necessary documentation and provide it to the homebound coordinator at the school**. **I also understand that any request for homebound services is subject to a 45-day review.**
- I understand that if homebound services are requested due to pregnancy; the Physician must document a complication that requires the student to receive homebound services.
- I understand that high-speed broadband internet access is necessary at the location selected for homebound services to be delivered.
- I understand that the instructor is responsible for instructional assignments for the approved dates of medical homebound services indicated by the physician on the homebound request. Any additional information or assignments prior to homebound approval are the responsibility of the parent and must be obtained from the school.
- I understand that all schedules and appointments must be met and, unless previous arrangements have been made with the instructor, that failure to adhere to the schedule/appointment may result in an unexcused absence for my child.
- I understand that if my child is found eligible for medical homebound services, she/he is subject to the same **mandatory attendance requirements** as other Beaufort County School Dist students.
- I understand that my child is responsible for submitting all instructional assignments and projects by the date set by the teacher.
- I understand that my child is expected to complete assignments in between homebound sessions and have them ready for when the instructor is present.
- I understand that a parent must be present for the entire homebound session.
- I understand that I do not get to choose my child's homebound instructor and that the instructor assigned is at the school's discretion.

I have read and agree to comply with the homebound policies and procedures and understand the reasons for possible dismissal from the program. Additionally, I understand that failure to adhere to these expectations may result in the student's dismissal from homebound services.

Signature of Parent/ Guardian: _____ Date:____/____/____

Signed Original remains at the school