HOME/HOSPITAL MEDICAL CERTIFICATION

Name of Student: _____ ID#:_____ DOB:_____

Names of Parent(s)/Guardian(s):_____

TO BE COMPLETED BY PHYSICIAN

Medical statement must be recertified by the treating health care provider every six (6) weeks

Please check one of the following:

☐ The student is able to attend school and is not eligible for home/hospital instruction.
Comments:_____

☐ The student is able to attend school with modifications or special provisions (i.e., partial days, rest between classes)
Describe modifcations needed:_____

☐ The student is unable to attend school at this time due to health concerns and requires home/hospital instruction.
Comments:_____

Medical Diagnosis:_____

_____

Specific reason(s) why the student is unable to attend school at this time:_____

_____

Impact on the student's ability to participate in education (i.e. the student's physical and mental level of tolerance for receiving educational services):_____

How long have you been seeing the patient for the diagnosis listed:_____

Will you be following the student: ☐ yes ☐ no If not, who will?_____

What is the treatment plan for the student: _____

_____

Approximate length of time the student will require Home/Hospital Instruction:_____
(days or weeks, not to exceed 6 weeks)

Anticipated date of return to school: (specific date must be indicated): _____

CERTIFICATION: I certify that this student is under my care and treatment for the aforementioned illness. This certifies that this treatment plan is medically necessary. It MUST be completed by the treating physician, psychiatrist, physician assistant or advanced practice registered nurse.

Health Care Provider's Name (print)_____ License #: _____

Hospital/Clinic/Practice: _____ Phone: _____

Health Care Provider's Signature: _____ Date: _____

Form must be sent directly from the Health Care Provider to:

Valerie Castaneda, Home/Hospital Coordinator
Glenbrook South High School
Email: vcastaneda@glenbrook225.org
Phone: 847-486-4536
Fax: 847-901-6793

Charmaine Rasavong, Home/Hospital Coordinator
Glenbrook North High School
Email: crasavong@glenbrook225.org
Phone: 847-509-2531
Fax: 847-509-2603