Home and Hospital Instruction Medical Certification

Revised: April 2023

In accordance with Board Policy 6:160, students may be eligible for home or hospital instruction with an approved medical certification. **Medical certifications must be provided using this form, recertified by the treating provider every six (6) weeks, and submitted directly to the appropriate Home and Hospital Instruction Coordinator**:

- ☐ Glenbrook North: gbn-homehospital@glenbrook225.org **or** fax (847) 509-2603
- ☐ Glenbrook South: gbs-homehospital@glenbrook225.org **or** fax (847) 901-6793

Part 1: Student Information

Name (First, Middle, Last)	Date of Birth	Student ID Number	Home School
			☐ GBN ☐ GBS

Part 2: Healthcare Provider to Complete (e.g., Physician, MD, DO, APRN, or PA)

Please check one of the following. The student is:

- ☐ Able to attend school and is not eligible for home or hospital instruction.
- ☐ Able to attend school with modifications or special provisions as indicated in the "Comments" section.
- ☐ Unable to attend school at this time due to health concerns and requires home or hospital instruction.

Comments: _____

_____

If the student requires home or hospital instruction, please fill out the remaining information in this section:

Medical Diagnosis: _____

_____

Treatment Plan: _____

_____

Impact on the student's ability to participate in education: _____

_____

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

_____

How long have you been seeing the patient for this diagnosis? _____

Will you be following the student? ☐ Yes ☐ No If 'No', who will? _____

Approximate length of time the student will require Home/Hospital Instruction: _____

Anticipated date of return to school: _____

Part 3: Certification

By signing below, I certify that the student identified in Part 1 is under my care and treatment for the aforementioned illness. This certifies that this treatment plan is medically necessary.

Healthcare Provider Name *(Type/Print)* _____ License Number: _____

Hospital/Clinic/Practice: _____ Office Phone Number: _____

Healthcare Provider Signature: _____ Date: _____