



Bulloch County Board of Education
HOSPITAL HOMEBOUND INSTRUCTION
REFERRAL

Directions: This form is to be completed by the student's school, parent and physician. This form must be signed by the school principal before it is sent to the Hospital Homebound staff. Once complete, forward this referral IMMEDIATELY to the office of Leslie Schlierf at the William James Educational Complex, fax number 912-212-8609. Upon receiving the form, it will be reviewed and the necessary meeting between the school, the parent and the HHB staff will be set up.

I. STUDENT INFORMATION

Student Name _____ DOB _____ Date of Referral _____
Parent Name _____ Telephone _____
Address _____
School _____ Grade _____ Regular Ed. _____ Special Ed. _____
Homeroom _____ Last Date of Attendance _____ Date Form Given to Parent _____

Principal's Signature _____ Date _____

II. PARENTAL PERMISSION

I, _____, request Hospital Homebound services for my child, _____.

I hereby give my permission for exchange of confidential medical information of my child between Bulloch County Board of Education and any necessary physician in order for the school system to make appropriate decisions for the education of my child. I have read and understand the HHB policies.

Parent signature _____ Date _____

III. MEDICAL CERTIFICATION

Medical Diagnosis with medical implications for instruction:

The above student is expected to need HHB instruction for _____ weeks beginning on _____. (Expected time to be out should be at least 10 regular school days or 5 days of block instruction.) The student is able to participate in and benefit from an instructional program without endangering health and safety of self, the instructor or other students.

Doctor's Printed Name _____ Address _____

Doctor's Signature _____ Telephone _____

Approved _____ Not Approved (Reason) _____

Date _____ Director _____

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Estimated Duration of HHB Services:

Starting Date: _____

Ending Date: _____

Date of Next Scheduled Appointment: _____

Physician's Statement: (Note: Please answer the following questions keeping in mind that the least restrictive environment is preferred.)

- Is the student unable to attend school for a minimum of ten consecutive school days?

Yes No

- Will the student be able to benefit from an instructional program during this time of confinement?

Yes No

- Could the student attend school with accommodations? If so, describe.

Yes No

Recommendations for Accommodations:

- Could the student attend school regularly and receive HHB services on an intermittent basis as needed?

Yes No

- Is the student confined to the home or hospital and full-time HHB services are recommended?

Yes No

- Is the student free from communicable diseases, such as flu or contagious airborne diseases?

Yes No

- Can instruction be provided to the student without endangering the health of the teacher or other students whom the teacher may contact?

Yes No (**NOTE:** You may periodically have to verify that the student remains under your care and continues to qualify for the HHB services program.)

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Treatment and School Reentry Plan (Note: The following information is required to determine eligibility for HHB services and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented.)

- What is the scheduled frequency of treatment/therapy for this student?

Daily Weekly Monthly

- What is the expected duration of the treatment/therapy? _____

- Will the student take medication?

Yes No

Medications student will take for diagnosis:

Name of medication	Effects on student's ability to comprehend	Effects on student's ability to complete independent assignments	Effects on student's ability to relate to teachers and other students

- Could this student return to school on an intermittent basis after his or her medication and condition is stabilized?

Yes No

- Can this student come into contact with other students?

Yes No

The HHB services program is designed to be a temporary educational program to help students who are unable to attend school for medical or psychiatric reasons. Please describe your time frame and transitional plan for the student's reentry to school (attach additional pages as needed).
