Smiley Campus
600 S. Smiley
O'Fallon, IL 62269
(618) 632-3507 phone
(618) 632-9730 fax

OTHS

O'FALLON TOWNSHIP HIGH SCHOOL
District #203

Milburn Campus
650 Milburn School Rd
O'Fallon, IL 62269
(618) 622-9647 phone
(618) 622-9630 fax

MEDICAL CERTIFICATION FOR HOME/HOSPITAL INSTRUCTION

Complete this form and retain on at the O'Fallon Township High School Special Services Department. Do not submit this form to the State Board of Education, but make this form available for auditing purposes.

Students may need to be educated temporarily away from the school building due to a medical condition (physical or mental). When a student needs to be away from the school building for a minimum of two or more consecutive weeks of school or ongoing intermittent absences totaling 10 or more school days, the student may be eligible for instruction at home or in a hospital (or other setting) by a qualified teacher. (34 CFR 300.39 and 300.115 and Section 14-13.01 of the school code [105 ILCS 5/14-13.01(a)] and ISBE Rule 226.300). It is not necessary for the student to have an IEP or 504 plan to qualify, although either may be created depending on student need and school procedures.

Parents: Please return this form to the O'Fallon Township High School Special Services Department promptly as services cannot be started until medical information is received.

Upon receipt of medical certification, the school district will provide home/hospital services for an eligible student.
** It should be noted that a child receiving homebound services is not eligible to participate in extra-curricular activities as defined in the Parent/Student Handbook.

SECTION 1- THIS SECTION FOR SCHOOL DISTRICT USE ONLY

Date of Application:		
Anticipated Dates of Homebound Services:	**From:** ________________ **To:** _________________	
Student Name:	**Gender:** ☐ **M** ☐ **F**	**Grade Level:**
Student Address: (Street, City, State, Zip Code)	**Name of Parent or Guardian:**	
Student Date of Birth:	**Parent Phone Number # (include area code)**	
School District Name:	**Home School Name:**	
School District Address (Street, City, Zip Code)	**School Address:**	
District Phone # (Include Area Code):	**School Phone #:**	
Homebound Teacher:	**Homebound Teacher Phone #:**	
	Homebound Teacher email:	

SECTION 2- TO BE COMPLETED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL ITS BRANCHES (M.D OR D.O)

DIAGNOSIS (Please fill in the following information below)	
Disease/ Injury/ Surgery (Primary Diagnosis):	
If disease, is the disease communicable: ☐ **Yes** ☐ **No**	If yes, please provide instruction to school staff in space below labeled **"SPECIAL RECOMMENDATIONS FOR TEACHERS/STAFF"**
Drug/Alcohol Treatment:	
Pregnancy (Including Postpartum):	
Mental Health/ Emotional Health:	
Other (Please Describe):	

I certify that this student is unable to attend public school and is medically eligible and physically able to be enrolled in the following program. (Check one only) ☐ *Home Instruction* ☐ *Hospital Class or Bedside*

The physician must estimate that the student will need the home or hospital instruction for a minimum of 10 school days this school year. The time may be longer than 10 days; if unable to determine approximate length of time, physician may estimate 'through end of school year' as long as the time period is at least 10 days.

Special Recommendations to Teachers:	**Estimated length of time student will require homebound instruction this year, if possible. (In weeks)**
Type or Print Name of Physician:	**Original Signature of Physician**:

SECTION 3- PARENT CONSENT

<table>
<tr><td rowspan="2">Parent Name Printed/Typed:</td><td>Parent Signature:</td></tr>
<tr><td>Date:</td></tr>
<tr><td colspan="2">Check One: ☐ I give consent ☐ I do NOT give consent to this Home & Hospital Education Program</td></tr>
<tr><td rowspan="2">SCHOOL DISTRICT USE ONLY</td><td>Date Home/Hospital instruction began:</td></tr>
<tr><td>Date of Termination of Home/ Hospital Program:</td></tr>
</table>