

TREATMENT AND SCHOOL RE-ENTRY PLAN



Dear Treating Physician:

The following information is required to determine eligibility for homebound/hospital services, and it must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented.

1. What is the scheduled frequency of treatment/therapy for this student?
 - Daily
 - Weekly
 - Monthly
2. What is the expected duration of the treatment/therapy? _____
3. Will the student take medication? Yes No
4. List below the medications this 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

5. Could this student return to school on an intermittent basis after his or her medication and condition is stabilized?
 - Yes
 - No
6. Can this student come into contact with other students?
 - Yes
 - No
7. The homebound/hospital services program is designed to be a temporary educational program to help students who are unable to attend school for medical or emotional or psychiatric reasons. Please describe your time frame and transitional plan for the student's re-entry to school. (You may attach additional pages, as needed.)

Physician's Certification: I certify that this student is under my care and treatment for the aforementioned medical condition. My recommendation has been based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.

Physician's/Psychiatrist's Printed Name

Date

Physician's/Psychiatrist's Signature

Date

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