HOMEBOUND INSTRUCTION MEDICAL CERTIFICATION OF NEED

Homebound instruction shall be made available to students who are confined at home or in a health care facility for periods that would prevent normal school attendance. The term "confined at home or in a health care facility" means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment. Students receiving homebound instruction may not work or participate in extra-curricular activities (school dances/games), non-academic activities (field trips/employment) or community activities unless these activities are specifically outlined in the student's medical plan of care or the Individualized Education Program (if applicable).

Homebound instruction has been requested for: _____

Student's DOB: _____/_____/_____ Age: _____ Sex: _____

Student's School: _____ Grade: _____

Parent/Guardian Name:_____

Address:

_____

Acknowledgement/Release: I acknowledge this request and agree with the need for homebound services. I further acknowledge that the requested homebound services for students receiving special education services shall be subject to review by the student's IEP team pursuant to the Individuals with Disabilities Education Act. I will provide an environment conducive to learning, ensure that a responsible adult is in the home for the duration of instruction, or provide transportation to another agreed upon facility if necessary. I will keep appointments with the homebound teacher or contact the teacher if an appointment must be missed.

I understand that the school system has established policies and procedures for homebound instruction that provide more detail than this certificate of need.

By my signature, I authorize the release and exchange of medical information between the health care provider, or his/her designee, and school personnel. My signature provides the health care provider(s) with the authorization necessary to disclose protected health information and records regarding said student as it pertains to the condition for which homebound instructional services are being requested. This authorization may be withdrawn at any time in writing.

_____ _____

Signature of Parent/Guardian Date

Request for Homebound Services

Homebound instruction is designed to provide continuity of educational services between the classroom and home or health care facility for students whose medical needs, both physical and psychiatric, do not allow school attendance for a limited period of time. At the time of the initial request, the physician, or psychiatrist providing medical certification of need for homebound instruction must provide the school the following:

Name of Student: _____

School: _____ Grade: _____

Nature and extent of illness: _____

Date of examination or diagnosis of this illness: _____

Is the student confined at home or in a health care facility? _____ Yes _____ No

Is the illness/treatment intermittent in nature (e.g., sickle cell anemia, chemotherapy? ___Yes ____No

Could this child attend school if accommodations are made by the school? _____ Yes ____No

If yes, please list the accommodations required. If no, please explain _____

_____

_____

Estimated date of return to school: _____

Explain ongoing treatment and/or therapy being provided: _____

Frequency of treatment: _____

_____

Signature of Licensed Physician/Psychiatrist Date

_____

Printed Licensed Physician/Psychiatrist Name Telephone Number

_____

If the initial request for services is for a DSM-V diagnosis, a treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required OR if it is necessary for homebound instruction to continue beyond a period of current nine weeks, an extension for reauthorization form, along with this same information will need to be provided to assess continued services.

PLEASE NOTE: This form, including parental permission to contact the treating physician or psychiatrist, must be fully completed in order for the student to be considered for homebound services. Completed forms should be submitted to the school counselor who will be responsible for forwarding to the Homebound Coordinator. If you have questions about completing this form, please contact the school counselor.

I hereby approve homebound instruction for this student, and further, certify that the teacher to be employed will hold a certificate in full force issued in accordance with the rules and regulations of the State Board of Education.

Homebound Coordinator: _____ Date: _____