EXCEPTIONAL STUDENT EDUCATION
REQUEST FOR CONSIDERATION OF
HOMEBOUND/HOSPITALIZED INSTRUCTION

To be considered for Homebound/Hospitalized instruction, it is necessary that the referring physician make a recommendation to the school.

SECTION I – STUDENT INFORMATION

Student Name		Birthdate	
Address		City	Zip
Parent Name		Home #	Cell#
School	Student ID	Grade	

SECTION II – LICENSED PHYSICIAN

Physician Name		Physician Specialty	
Address		City	Zip
Phone	Fax		

SECTION III: MEDICAL STATEMENT - COMPLETED BY THE PHYSICIAN

Completion of this form is a required part of the eligibility process and does not guarantee placement in the Hospital/Homebound program. Failure to complete this form in its entirety and return it in a timely manner may result in a delay of eligibility determination.

Please note that Hospital/Homebound services do not duplicate the comprehensive classroom experience.

Medical Condition: Describe the condition(s) which confines the student to home or hospital. Attach additional documentation if necessary. Per SBER 6A-6.03020 F.A.C., a homebound or hospitalized student is a student who has a diagnosed medical or psychiatric condition which is acute in nature, or a chronic illness, or a repeated intermittent illness due to a persisting medical problem and which confines the student to home or hospital, and restricts activities for an extended period of time.

Medical Condition:	**DX Code:**

Expected Return School Date:
(MM/DD/YYYY)

An anticipated date of return to school must be determined by the physician. If an undetermined date is indicated, the form will be returned to the physician. If, during treatment, the physician needs to extend the expected school return date, the physician may do so by submitting a new form which reflects the revised date of return. If the student can return to school prior to the expected date, a Physician's Release to Return to School Form will be required.

All questions must be answered and initialed by the physician in order to consider eligibility for Homebound/Hospitalized instruction. Students who do not meet all of the criteria below may not be eligible.

YES	NO		
		Initial ____	1. Is the student expected to be absent from school due to a physical or psychiatric condition for at least 15 consecutive school days, or due to a chronic condition for at least 15 school days during the school year?
		Initial ____	2. Is the student confined to home or hospital?
		Initial ____	3. Will the student be able to participate in and benefit from the instructional program?
		Initial ____	4. Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature?

Section IV: Physician's Treatment Plan – Please answer each question below. In your professional opinion:

Is this child's diagnosed problem sufficiently severe to cause significantly debilitating effects on the child's physical or psychological health? Yes No If yes, explain the nature and extent of these effects.
Is this child's physical or mental condition likely to be significantly improved with treatment? Yes No If yes, please explain the reasons for your opinion.
Is the nature of this child's physical or mental condition such that potential negative effects would occur with regular school attendance? Yes No If yes, please explain the reasons for your opinion.
Briefly describe current **Medical Treatment Plan**.
Recommendations for School Re-Entry: Include the components of your plan which specifically address medication, therapy/treatments, participation in employment and extra-curricular activities etc.

***Confinement Levels:** Per SBER 6A-6.03020 F.A.C., the physician must certify that the student is unable to attend school.

Based on your examination, which level of confinement do you recommend for consideration?

	Intermittent	This student is currently able to attend school; however, it is expected that he/she will experience intermittent days of hospitalization or home confinement.
	Part-Time	This student is currently confined to the hospital or home, part-time and able to attend school on a part-time basis.
	Full-Time	This student is currently confined to the hospital or home full-time and unable to attend school on a regular basis.

Printed Name -Physician/ P.A. / A.R.N.P **Signature of Physician / P.A. / A.R.N.P.** **Date**

Signature must be an original signature. Reproduction such as a stamp will not be accepted. An ARNP or PA working for a licensed physician may sign the medical statement. The name of the physician must also be recorded, in addition to the ARNP or PA. However, in this case, the licensed physician's signature is not required.

Please return the completed form to the Intervention Support Specialist at your child's school.