

Student Name

## EXCEPTIONAL STUDENT EDUCATION REQUEST FOR CONSIDERATION OF HOMEBOUND/HOSPITALIZED INSTRUCTION

Birthdate

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

## **SECTION I – STUDENT INFORMATION**

Address							City		Zip	
Parent Name						Hor	ne#	Cell#	1	
School					Grade					
TION	II – LICEN	SED PHYSICIAN								
Physician Name					Physic	sician Specialty				
Address					City			Zip		
ne				Fax	I					
TION	III: MEDIC	AL STATEMENT - COMPI	LE.	TED BY THE	PHYS	ICI	AN			
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.										
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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.										
ical Co	ndition:				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.										
								Homeboun	d/Hospitalized	
NO										
	Initial									
	Initial	2. Is the student confined to	ho	me or hospital	?					
	Initial	3. Will the student be able to	о ра	articipate in and	d benef	fit fro	om the instruct	ional progi	ram?	
	Initial	4. Is the student under med nature?	ical	care for illness	s or inju	ıry v	hich is acute,	catastroph	nic, or chronic in	
	TION Sician Notes TION Deletion ital/Ho of eligible of a pended prical Commentation of a pended prical Counticipal will be in to so usestion uction.	TION II – LICENS sician Name ress ne  TION III: MEDIC coletion of this form ital/Homebound pr of eligibility detern se note that Hospital cal Condition: De mentation if necess nosed medical or pr of a persisting med ital Condition:  cted Return School M/DD/YYYY) anticipated date of will be returned to the physician material to school prior to uestions must be a uction. Students will  NO  Initial  Initial  Initial  Initial  Initial	TION II – LICENSED PHYSICIAN  Sician Name  TION III: MEDICAL STATEMENT - COMP  Deletion of this form is a required part of the eligibilital/Homebound program. Failure to complete the of eligibility determination.  See note that Hospital/Homebound services do not cal Condition: Describe the condition(s) which mentation if necessary. 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Per SBER 6A-6.03020 F.A.C., a homebound or hospicosed medical or psychiatric condition which is acute in nature, or a chronic if of a persisting medical problem and which confines the student to home or hose deed period of time.  Ical Condition:  Coted Return School Date:  M/DD/YYYY)  Initicipated date of return to school must be determined by the physician needs to the physician may do so by submitting a new form which reflects the revise in to school prior to the expected date, a Physician's Release to Return to Since the submitted prior of the expected date, a Physician's Release to Return to Since the submitted prior of the expected date, and the physician in order to consider uction. Students who do not meet all of the criteria below may not be eligible.  No  Initial  1. Is the student expected to be absent from school due at least 15 consecutive school days, or due to a chronic 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 Initial  4. Is the student under medical care for illness or injury we have the properties of the participate in and benefit from Initial  4. Is the student under medical care for illness or injury we have the properties of the participate in and benefit from Initial  4. Is the student under medical care for illness or injury we have the properties and the prop	TION II – LICENSED PHYSICIAN  Sician Name  Physician Specialty  City  TON III: MEDICAL STATEMENT - COMPLETED BY THE PHYSICIAN  Soletion of this form is a required part of the eligibility process and does not guarantee placetiat/Homebound program. Failure to complete this form in its entirety and return it in a time of eligibility determination.  Cal Condition: Describe the condition(s) which confines the student to home or hospital. A mentation if necessary. 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Per SBER 6A-6.03020 F.A.C., a homebound or hospitalized student is a studiosed medical or psychiatric condition which is acute in nature, or a chronic illness, or a repeated interest of the physician medical problem and which confines the student to home or hospital, and restricts active ded period of time.  Ical Condition: DX Code  Code Code Code Code Code Code Code Code	

Section IV: Physicia	n's Treatment Plan – Please answer each question below. In your professional opinion:
Is this child's diagnose psychological health?	ed problem sufficiently severe to cause significantly debilitating effects on the child's physical o Yes No If <u>yes</u> , explain the nature and extent of these effects.
Is this child's physical c explain the reasons for	r mental condition likely to be significantly improved with treatment? Yes No If <u>yes</u> , please your opinion.
Is the nature of this chil attendance? Yes	d's physical or mental condition such that potential negative effects would occur with regular school  No If <u>yes</u> , please explain the reasons for your opinion.
Briefly describe current	Medical Treatment Plan.
	r School Re-Entry: Include the components of your plan which specifically address medication, ticipation in employment and extra-curricular activities etc.
attend school.	s: Per SBER 6A-6.03020 F.A.C., the physician must certify that the student is unable to lation, 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 -Physi	cian/ 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.