



To: Medical Physician
 From: Antoinette Linker, Coordinator of IDEA
 RE: Homebound Physican's Letter

To the Treating Physician

St. Charles Parish Public Schools provides instruction for students, who because of **health care treatment, physical illness, accident or the treatment** thereof, are temporarily unable to attend school and are confined to the home for a **minimum of 10 school days**. Instruction in the home is a temporary arrangement that allows the student under medical care to continue to receive instruction in accordance with SCPPS curriculum so the student can re-engage successfully in the instruction program upon return to school.

Please be aware that homebound instruction cannot replicate the full array of services available at a regular school campus and does not provide social and peer interaction available at the student's school. For instruction provided in the home, the state of Louisiana considers 4 hours of direct instruction to be equivalent to a full week of school. ***While the student is receiving homebound services, the student is unable to attend extracurricular activities or have a job.***

Please complete the document and return to the special education department so that homebound eligibility may be determined. Feel free to contact me with any questions.

Sincerely,

Antoinette C Linker
 Coordinator of IDEA
 St. Charles Parish Public Schools
 985.785.3171

*I have read this document and feel that **temporary homebound services** would be the most appropriate setting for my patient at this time.

 Original signature of Medical Doctor

 Date

****If you feel that an amended day or accommodations for a temporary period would be sufficient for your patient to attend school, please send a letter to the Coordinator of IDEA with your suggestions.**



St. Charles Parish Public Schools
Application for Medical Reasons Homebound Instruction

Completion of this application does not guarantee homebound eligibility. Students must be absent for 10 consecutive days before homebound will be considered. Students are responsible for all makeup work missed during the time homebound is being considered.

Name _____ Sex _____ D.O.B. _____ Grade _____
Home Address _____ City _____ Zip _____
Parent(s) Name _____ Phone Number _____
Parent email address _____
School _____

Does this student receive Special Education Services? Yes or No _____ Does the student have a 504 Plan? Yes or No _____

Last date the student attended school _____ Parent Signature _____

MEDICAL CERTIFICATION: This section must be completed by a properly certified MEDICAL DOCTOR.

1. Specific medically diagnosed illness which **prohibits school attendance.** (A diagnosis of ADD/ADHD, anxiety/phobia, autism, behavior disorder, depression, etc. is not a qualifying diagnosis for homebound services on its own. Question 2 must explain the acute episode) *NOTE: Mental Health conditions require a different form.*

2. How does this acute diagnosis confine the student to the home and limit activities including school, extracurricular activities, driving, social outings with friends, and employment?

3. Pregnancy

a. Expected Delivery Date: _____

b. The student is experiencing the following complication in her pregnancy (or recovery) which would be detrimental to her health or the health of her fetus/offspring _____

c. The student's expected recovery period _____

4. Recommendations for the school setting upon the student's return (this may be adjusted as necessary closer to the student's return via letter). _____

5. Estimated length of time the student will be unable to attend school? A new application is necessary after 6 weeks to determine continued eligibility. Circle one:

3 weeks

4 weeks

5 weeks

6 weeks

Medical Dctor Signature _____ Date _____

Printed Name _____ Phone number _____

Physician's address _____ Fax Number _____

A student will not be considered for homebound instruction if this form is not filled out correctly and fully



Consent for Disclosure of Case Information
St. Charles Parish Public Schools

Student name:	Parent(s) Name
DOB	Address:
	City, State, Zip:
Requested by: Antoinette Linker, Coordinator of IDEA St. Charles Parish Public Schools 985.785.3171	Parent phone number:

I, the parent/legal guardian of the above child, am approving the release of his/her records from your agency. I understand that the information contained in his/her record is confidential. However, I give consent for:

Name/Agency _____
Address: _____

To release the following information:

<ul style="list-style-type: none">• Medical	<ul style="list-style-type: none">• Diagnostic findings	<ul style="list-style-type: none">• Treatment/programming
<ul style="list-style-type: none">• Social	<ul style="list-style-type: none">• Educational implications	<ul style="list-style-type: none">• Prescription for treatment
<ul style="list-style-type: none">• Psychological	<ul style="list-style-type: none">• Speech	<ul style="list-style-type: none">• Sensory
<ul style="list-style-type: none">• Other _____		

The purpose of this release is for SCPPS to evaluate the eligibility for homebound services.

I understand that:

1. I may refuse this authorization, and it is strictly voluntary. I acknowledge receiving a copy of this.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken before receiving the revocation.
4. If the requester or receiver is not a health plan or a healthcare provider, the released information may no longer be protected by Federal Privacy Regulation and may be disclosed.

This authorization will expire on the following date or event:

- Date: _____ or
- Event: **One (1) Calendar Year from the date of application.**

Signature of parent/legal guardian

Date