CECIL COUNTY PUBLIC SCHOOLS
HOME AND HOSPITAL EDUCATION

ADMINISTRATIVE SERVICES CENTER
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Superintendent of Schools

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Home and Hospital Extension Request Form - SY26-27

Section 1: Student Information (Please print clearly)

Student Name: _____

Date of Birth: _____

School of Enrollment: _____

Grade Level: _____

Section 2: Medical Provider Statement

Physical Health Conditions - Only to be completed by: A Licensed Physician or Certified Nurse Practitioner

Mental Health Condition - Only to be completed by: A Licensed Psychiatrist, Licensed Psychologist, Certified School Psychologist, or Psychiatric Mental Health Nurse/Practitioner

Treating Medical Professional's Name:(please print)_____

Check the appropriate box below. If your title is not listed, you are not legally licensed to recommend Home and Hospital Services in MD and should not complete this form!

☐ Licensed Physician ☐ Nurse Practitioner ☐ Certified Mental Health Nurse Practitioner ☐ Licensed Psychiatrist
☐ Licensed Psychologist ☐ Certified School Psychologist

Email Address: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

1. Primary Health Condition/Diagnosis:

Please identify the specific health condition(s) currently impacting the student's ability to attend school.

_____
_____
_____
_____
_____
_____
_____

2. Clinical Justification for Extension:

Please explain why this medical condition prevents the student from participating in the traditional school setting (e.g., risk of infection, severe mobility limitations, acute psychological distress, intensive treatment schedule).

_____
_____
_____
_____
_____
_____
_____
_____

3. Current Treatment Plan:

Briefly describe the ongoing treatment or interventions the student is receiving during this extension period.

_____
_____
_____
_____
_____
_____
_____
_____

Section 3: Reintegration & Return-to-School Plan

(ONLY to be completed by a licensed physician, certified nurse practitioner, licensed psychiatrist, licensed psychologist, psychiatric mental health nurse practitioner, or certified school psychologist)

A clear path for returning to the school setting is required for approval.

Today's Date: _____

Estimated Return Date: _____

Transition Requirements: *Check all that apply to the student's successful return:*

- [ ] Reduced/Partial day schedule
- [ ] Specific physical accommodations (e.g., elevator access, specialized seating)
- [ ] Support from school counselor/psychologist
- [ ] Medication administration during school hours
- [ ] Other:

_____
_____
_____
_____
_____

Specific Milestones for Return:

What clinical or functional markers must be met before the student can safely return to the home school setting?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section 4: Provider Verification

By signing below, I certify that this student is under my care and that the medical condition described necessitates continued home/hospital instruction.

Provider Name (Print): _____ Title: _____

Phone: _____ Fax:_____

Clinic/Hospital Name: _____

Signature: _____ Date: _____

Section 5: Internal Use Only (School Administration)

- Date Received: _____
- Extension Status: [ ] Approved [ ] Denied [ ] Pending Additional Info
- Administrator Signature: _____