



Clayton County Public Schools

Hospital-Homebound Department

1588 Lovejoy Road – Hampton, Georgia 30228

Phone: 678-817-3119 Cell: 678-977-3751 Fax: 678-817-3097



Medical Certification Form for Psychiatric Diagnosis

Please fax the completed Medical Certification Form to ATTN: Dr. Quintella Harrell-678-817-3097

Incomplete and/or hand-delivered Medical Certification Forms will not be processed.

Hospital Homebound (HHB) instruction is an academic service provided to students who are unable to attend school due to confinement at home or in a health care facility, as certified by the licensed psychiatrist currently treating the student for the presenting condition.

Eligibility Requirements:

- To be considered for HHB services, the attending psychiatrist must certify that the student's medical condition will prevent school attendance for a minimum of **ten (10) consecutive school days**.
- **HHB services for psychiatric diagnoses are limited to a maximum of eight (8) weeks.** If the student's condition is expected to extend beyond this period, the parent/guardian, school counselor, and HHB teacher should collaborate with the District Exceptional Student (DES) lead and 504 designees to determine if a 504 or an Individualized Education Program (IEP) is appropriate.

Psychiatric Requirements:

- Students approved for HHB services due to a psychiatric diagnosis must have a **comprehensive psychiatric evaluation and ongoing psychological counseling**.
- The psychiatric evaluation must include:
 - Patient History
 - Examination findings
 - Diagnosis
 - Prognosis
- A copy of the **therapy/counseling schedule** must be attached to this form, as district procedures require active therapy for continued HHB eligibility.
- A **Treatment and School Re-Entry Plan** must also be documented and submitted with this form.

Important Note:

HHB instruction is designed as a **support service** and is not intended to replace regular classroom instruction. Students are encouraged to return to their regular school setting as soon as medically appropriate.



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Medical Certification Form for Psychiatric Diagnoses

(Note: To be completed by a licensed psychiatrist (or designee) and faxed or emailed back to HHB at 678-817-3097)

Name of Student: _____ **ID#:** _____ **Age:** _____ **DOB:** _____

Name of Psychiatrist: _____ **Psychiatrist GA Provider#:** _____

Phone Number: _____ **Ext.:** _____ **Fax Number:** _____

Office Address: _____

Date of Initial Evaluation: _____ **Date of Next Appointment:** _____

Diagnosis: _____

Length of Time Student Will Need HHB Instruction:

Number of Weeks: _____ **Starting Date:** _____ **Ending Date:** _____

Psychiatrist's Statement: Please answer the following questions by checking yes or no.

- Is the student unable to attend school for a minimum of 10 consecutive days? Yes _____ No _____
- Is the student confined to the home or hospital? Yes _____ No _____
- Are full time HHB services recommended? Yes _____ No _____
- The student who has a chronic or long-term illness and who will be absent from school ten days in the year may receive *intermittent HHB services rather than full-time HHB services. Is this an option for the student? Yes _____ No _____
- Can instruction be provided without endangering the health or safety of the instructor or other students with whom the instructor may come in contact? Yes _____ No _____
- Does the student have a communicable disease? Yes _____ No _____
- Is the student able to participate in and benefit from an instructional program? Yes _____ No _____

***If the student is approved for intermittent HHB services, medical updates will be required on a schedule defined within the Student's Educational Service Plan (ESP)**



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Medical Certification Form for Psychiatric Diagnosis

Student's Name: _____ ID# _____ DOB: _____

Please indicate any limitations or restrictions during HHB instruction, including medication effects.

Treatment and School Re-entry Plan (Required)

The following information is required to determine eligibility for Hospital - Homebound instruction and must be completed by the licensed psychiatrist currently treating the student for the diagnosis presented.

- What is the treatment/therapy schedule for this student? Daily _____ Weekly _____ Monthly _____
- What is the expected duration of the treatment/therapy? _____
- Could the student return to school on an intermittent basis after his/her medication or condition is stabilized? If applicable, please explain below.

Medical Certification Form for Psychiatric

Diagnosis

Hospital-Homebound (HHB) Instruction

Hospital-Homebound (HHB) instruction is a temporary academic support service designed to assist students who are unable to physically attend school due to a verified medical or psychiatric condition. HHB services are not intended to substitute for the student's regular classroom instruction. For students with psychiatric diagnoses, HHB services may be provided for a maximum duration of eight (8) weeks. Therefore, students are encouraged to return to a school setting as soon as they are medically able to do so.

Please describe below (or attach documentation of) the anticipated timeframe for services and the proposed transitional plan to support the student's re-entry into the school environment.



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Psychiatrist's Certification

Will the student take medication? YES_____ NO_____. If yes, please list the medications below:

List of Medications

Name of Medication	Effects on student's ability to comprehend	Effects on student's ability to complete independent assignments	Effects of student's ability to relate to teachers and other students

With the understanding that the Hospital/Homebound Program is the most restrictive educational environment, I certify that this student is under my care and treatment for the aforementioned medical condition and, in my professional opinion, it is medically necessary to place this child in this very restrictive educational environment

Psychiatrist's Signature

GA License Number

Date

Please Note: If this form is completed by a PA or ARNP, the supervising psychiatrist's name, signature, and phone number must also be provided below.



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Supervising Physician Name (Printed) _____

Signature of Supervising Physician _____ Date _____

Physician's Designee Name (Printed) _____

Signature of Physician's Designee _____ Date _____

Phone number of Supervising Physician: _____ Fax number: _____

Specialty: _____, _____, _____

Please fax the completed form to Dr. Quintella Harrell at **678-817-3097** or
email the form to **quintella.harrell@clayton.k12.ga.us**