CHRISTINA SCHOOL DISTRICT
Together, Educating Every Student for Excellence

CHRISTINA SCHOOL DISTRICT
Drew Educational Support Center
600 North Lombard Street
Wilmington, Delaware 19801

Student Services
Phone: (302) 552-2718
Fax: (302) 429-4142
TDD: (800) 232-5470

DAN SHELTON, ED.D.
Superintendent

Thea R. Scott
Homebound Instruction Coordinator

HOMEBOUND INSTRUCTION MEDICAL FORM

(All sections must be completed for consideration of approval)

TO BE COMPLETED BY SCHOOL:

Student Name: _____Age: _____ D.O.B. _____

Address: _____

IEP or 504 Plan: Yes__ __ No_____

School: _____ Grade: _____ **(Please include copy)**

Parent/Guardian Name: _____

Telephone: Work: _____ Cell: _____Email:_____

School Contact: _____Phone: _____Email:_____

TO BE COMPLETED BY PARENT/GUARDIAN:

Do you understand that homebound "supportive" instruction is an alternative educational program provided at home, in a hospital or at a related site for a student temporarily at home or hospitalized for a sudden illness, injury, episodic flare up of a chronic condition, accident, or pregnancy, childbirth or related medical condition to pregnancy or childbirth.

Yes_____ No_____ initial_____

Do you understand that Homebound Instruction is not a substitute for the classroom?

Yes_____ No_____ initial_____

Do you understand that Homebound Instruction is provided for **5** hours per week (K-5) or **7** hours per week (6-12)?

Yes_____ No_____ initial_____

Do you understand that you will need to provide medical and/or psychological updates upon request or homebound services will be terminated?

Yes_____ No_____ initial_____

If approved you agree to the following:

- You shall ensure that a responsible adult over the age of 21 will be present in the home for the entire period of homebound instruction
- You shall allow the teacher and student to work without distractions such as TV, radio, pets, etc.
- You shall notify the service provider within 24 hours if you need to cancel a scheduled appointment
- You shall arrange doctor's appointments, therapy, etc. so those appointments do not conflict with scheduled instruction
- You shall sign the teachers time sheet at the end of each instructional period
- You shall notify the school contact person if there are any discrepancies with homebound services
- You understand that homebound services will conclude if the physician recommends that the student can attend school
- You understand that failure to comply with the above conditions will result in termination of homebound instruction

_____ _____

Parent/Guardian Name (Please Print) Parent/ Guardian Signature

_____

Date

The Christina School District is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, pregnancy, national origin, citizenship, age, disability, veteran status, genetic information, sexual orientation, marital status, gender identity, or any other categories protected by federal, state, or local law. Inquiries regarding compliance with the above may be directed to the Title IX/Section 504 Coordinator, Christina School District, 600 North Lombard Street, Wilmington, DE 19801; (302) 552-2600.

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TO BE COMPLETED BY PHYSICIAN/PSYCHIATRIST/PSYCHOLOGIST or ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT (employed by or who has a collaborative and/or written agreement with a licensed physician:

Your patient, _____, has been recommended for Homebound Instruction. Do you understand that homebound "supportive" instruction is an alternative educational program provided at home, in a hospital or at a related site for students temporarily at home or hospitalized for a sudden illness, injury, episodic flare up of a chronic condition, accident, or pregnancy, childbirth, or related medical condition to pregnancy or childbirth. By signing this form you acknowledge and agree that this student will receive 5 hours of instruction per week (grades K-5) or 7 hours of instruction per week (grades 6-12). Please be certain your patient requires Homebound Instruction before completing this form. You may use separate sheet to provide additional information.

Diagnosis: _____

Prognosis: _____

Are you currently treating this patient? Yes_____ No____ If yes, last appointment date: _____ Next appointment_____

Medical/Psychological Treatment Plan/Interventions, etc. that will be utilized to assist the student in returning to school:
_____
Current status/disposition of patient: is the student confined to the hospital _____or home_____? (check one)
Yes_____ No_____
Anticipated length of time away from school: _____

Estimated Date Confinement Begins: _____Estimated Date Confinement Ends: _____

Is your patient expected to be absent from school due to a physical or psychological condition for at least 10 days?
Yes_____ No_____
Do you understand that homebound instruction is not a substitute for the classroom?
Yes_____ No_____
Will the student be able to participate in and benefit from an instructional program?
Yes_____ No_____
Provide details on why the medical/psychological condition prevents your patient from being instructed in a regular educational setting._____
_____

If patient is unable to attend school, describe previous attempts to bring your patient into a regular classroom.
_____
_____

Can any reasonable accommodations be made to keep your patient in the classroom? (Explain)_____
_____

_____ _____ _____
Doctor's Name (Please Print) Doctor's Signature (Rubber Stamp Not Acceptable) Date

_____ _____
Doctor's Telephone Number Address

RETURN TO: School Contact Person: _____Phone Number: _____

Email Address: _____Fax Number:_____

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