



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)

PAGE 1 OF 2

TO BE COMPLETED BY SCHOOL:

Student Name: Age: D.O.B.

Address:

School: Grade: IEP or 504 Plan: Yes No (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



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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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