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

Richard L. Gregg, Superintendent

CHRISTINA SCHOOL DISTRICT

HOMEBOUND INSTRUCTION MEDICAL FORM
(All sections must be completed for consideration of approval)

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?
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:_____

Richard L. Gregg, Superintendent