

## **HOMEBOUND EDUCATION MEDICAL CERTIFICATION FORM**

TO QUALIFY FOR THE HOMEBOUND INSTRUCTION PROGRAM, A STUDENT MUST HAVE A HEALTH IMPAIRMENT OF SUFFICIENT SERIOUSNESS TO ANTICIPATE THAT THE STUDENT WILL BE ASBENT FOR A MINIMUM OF TEN (10) CONSECUTIVE SCHOOL DAYS. THE STUDENT MUST BE CERTIFIED BY A PHYSICIAN OR APPROPRIATE HEALTH CARE PROVIDER AS BEING HEALTH IMPAIRED AND UNABLE TO ATTEND THE REGULAR INSTRUCTIONAL PROGRAM.

**STUDENT:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_ **SCHOOL:** \_\_\_\_\_

**PARENT:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_

### **TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER**

This student has been referred for the Homebound Instruction Program. Medical information is needed to plan an Homebound Individualized Educational Program. The information will be confidential and used only by persons directly involved with the student.

**Diagnosis/Etiology:**

**Prognosis:**

**Date Examined:** \_\_\_\_\_ **Date of Expected Return to School:** \_\_\_\_\_

**Physical Limitations Upon Return to School:**

**Risk to Child or Other Children Upon Return to School:**

**Check One:**

- \_\_\_\_\_ (1) This child is physically able to attend regular educational classes.
- \_\_\_\_\_ (2) This child is able to attend regular education classes for an abbreviated day.
- \_\_\_\_\_ (3) This child is unable to attend regular education classes, but is able to receive home/hospital instruction.
- \_\_\_\_\_ (4) This child is pregnant and should receive home instruction of the six weeks period beginning \_\_\_\_\_ and ending \_\_\_\_\_.

**Signature of Physician or Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

To Be Completed By Building Principal: School: \_\_\_\_\_ Teacher Assigned: \_\_\_\_\_

**Date Homebound Services Are To Begin:** \_\_\_\_\_