

## **CERTIFICATION OF NEED FOR MEDICAL HOMEBOUND INSTRUCTION**

Homebound instruction shall be made available to students who are confined at home or in a health care facility for periods that would prevent normal school attendance (8VAC20-131-180). The term "confined at home or in a health care facility" means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment. Students receiving homebound instruction may not work or participate in extra-curricular activities, non-academic activities (such as field trips), or community activities unless these activities are specifically outlined in the students medical plan of care or the Individualized Education Program (if applicable).

### **A. TO BE COMPLETED BY GUIDANCE COUNSELOR OR DESIGNEE**

Full Legal name of Student \_\_\_\_\_ Date of Birth     /    /     Age      Sex       
Parent's/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Father's Work Phone \_\_\_\_\_ Mother's Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

### **B. TO BE COMPLETED BY PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST**

Professional advice is necessary in determining whether or not the above named student is able to attend school. Please provide specific information regarding the following:

1. Is the student confined at home or in a health care facility? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. Illness/Injury/Diagnosis: \_\_\_\_\_ If pregnant, due date:     /    /
3. Would this student be able to attend school if accommodations were made?(e.g. rest periods, shortened day, elevator): \_\_\_\_\_
4. Detailed Description of Illness/Injury that prevents student from attending school \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Date of examination or diagnosis of this illness     /    /
6. Date of Eligibility for Homebound Instruction     /    /
7. Expected Date of Return to School     /    /
8. What limitations should be considered by school personnel in providing homebound services? \_\_\_\_\_
9. Is the illness/treatment intermittent in nature (e.g. sickle cell anemia, chemotherapy for childhood cancer)? \_\_\_\_\_ Yes \_\_\_\_\_ No
10. Specific goals and treatment plan (please include details i.e. medication, counseling schedule, etc. concerning plan to return the student to school: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Attach additional information if necessary.

Date \_\_\_\_\_ Signature of Licensed Physician/Clinical Psychologist \_\_\_\_\_  
Printed Name \_\_\_\_\_ Address \_\_\_\_\_ Phone No. \_\_\_\_\_

### **C. TO BE COMPLETED BY PARENT/GUARDIAN**

Acknowledgement/Release: I acknowledge this request and agree with the need for homebound services. I further acknowledge that the requested homebound services for students receiving sped. services shall be subject to review by the student's IEP team pursuant to the Individuals with Disabilities Educ. Act. I will provide an environment conducive to learning, ensure that a responsible adult is in the home for the duration of instruction, or provide transportation to another agreed upon facility. I will keep appointments with the homebound teacher or contact the teacher or homebound coordinator if an appointment must be missed.

I understand that the local school division has established policies and procedures for homebound instruction that provide more detail than this certificate of need.

By my signature, I authorize the release and exchange of medical information between the health care provider, listed on the reverse side, or his/her designee, and school division personnel. My signature provides the health care provider(s) with the authorization necessary to disclose protected health information and records regarding said student as it pertains to the condition for which homebound instructional services are being requested. This authorization may be withdrawn at anytime in writing.

**Note:**

*Students may receive instruction in the home, a health care facility, or any other approved facility as agreed upon by the school division and parent or student who has reached the age of majority (eligible student). If it is necessary for homebound instruction to continue beyond nine weeks, an extension or reauthorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.*

Please note: This form, including parental permission to contact the treating physician or psychologist, **must be fully completed** in order for the student to be considered for homebound services. If you have questions about completing this form, please contact: Office of Special Education, 450 Radio Lane, Culpeper, VA 22701 (540) 825-3677.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

