

MEDICAL HOMEBOUND INSTRUCTION FORM

Dear Physician:

Thank you for your dedication in keeping students in South Carolina healthy and progressing academically and socially in the regular school environment to the extent that is appropriate. The below named student and his/her parent, legal guardian, or surrogate parent has requested that the school district provide medical homebound instruction due to the student's inability to come to school as a result of an illness, accident, or pregnancy even with the aid of transportation. A district representative may contact you to discuss strategies to maintain the student in the school environment and to request additional information. The district superintendent or his/her designee must approve any student participating in a program for medical homebound instruction or hospitalized instruction. Please fully complete Section II as indicated.

SECTION I – STUDENT INFORMATION: (To be completed by school district personnel)

Student's Name:	Date of Birth:	Age:	Grade:
School:	School District:	Is this student classified as disabled? Yes ___ No ___ Category _____	

SECTION II – MEDICAL INFORMATION: (To be completed by a *licensed physician*)

Diagnosis of condition that <u>prevents</u> school attendance: (Attach additional information if needed)
Prognosis and Treatment:
How does this medical condition impact educational performance?
Beginning date of nonattendance: ____/____/____ Projected return date: ____/____/____
I certify that the above student cannot attend school because of illness, accident, or pregnancy, even with the aid of transportation but may profit from instruction given in the home or hospital.
Date: ____/____/____ Phone # _____ Address: _____
Printed Name: _____ Physician's Signature: _____

SECTION III – RELEASE: (To be completed by parent or by student, if eighteen or older)

I authorize the release of medical, educational, or mental health information to school officials. Date: ____/____/____ Signature of Parent/Legal Guardian/Surrogate Parent (or student if eighteen or older): _____
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SECTION IV – AUTHORIZATION: (To be signed and dated by the District Superintendent or Designee)

I certify that school officials will consider whether the student now qualifies under Section 504 of the Rehabilitation Act of 1973 or is eligible for entry into programs for children with disabilities. I further certify if this is a student with a disability in accordance with State Board of Education regulations and if the student's medical homebound placement constitutes a change of placement, an IEP committee with parental involvement will develop an individualized education program (IEP). Medical homebound services are authorized to begin on or after ____/____/____ Superintendent's or Designee's Signature: _____

The need for medical homebound instruction may be reviewed periodically. School districts must retain this document on file for a period of five (5) years in accordance with procedures set forth in the South Carolina Pupil Accounting System Instruction Manual.