Clayton County Public Schools
Hospital-Homebound Department
1588 Lovejoy Road – Hampton, Georgia
Phone: 678-817-3119 Fax: 678-827-8096

Medical Certification Form for **Psychiatric Diagnosis**

Incomplete and/or hand-delivered Medical Certification Forms will not be processed for Hospital-Homebound

Hospital-Homebound (HHB) instruction is academic instruction provided to students who are confined at home or in a health care facility for periods of time that would prevent normal school attendance based upon medical certification of need by the licensed psychiatrist who is treating the student for the presenting diagnosis. To be considered eligible for HHB instructional services, the student's attending psychiatrist anticipates student absences for a minimum of ten consecutive school days. HHB services will, under no circumstances, exceed eight weeks. If the attending psychiatrist anticipates that the condition will exceed eight weeks, the parent is encouraged to speak with the school counselor to get a 504 or IEP in place.

Students who are determined eligible for Hospital/Homebound services due to a psychiatric diagnosis are required to have a psychiatric evaluation and on-going psychological counseling. The psychiatric evaluation must include a history, examination findings, diagnosis, and a prognosis. Since CCPS district procedures require therapy for continued HHB eligibility, the therapy schedule should be attached to this form. Consideration for HHB also requires a documented Treatment and School Re-entry Plan. This plan should be attached. Psychiatrists are reminded that Hospital-Homebound instruction is offered as a support service and not intended to replace regular classroom instruction. Therefore, students are encouraged to return to school as soon as possible.

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(Note: This form must be completed by a licensed psychiatrist (or designee) and faxed or emailed back to HHB)

Name of Student: _____ Age: _____ DOB: _____

Name of Psychiatrist: _____ Psychiatrist GA Provider #: _____

Phone Number: _____Ext. _____ Fax Number: _____

Office Address: _____

Date of Initial Evaluation: _____ Date of Next Appointment: _____

Diagnosis: _____

Length of Time Student Will Need HHB Instruction:

Number of Weeks: _____ Starting Date: _____ Ending Date: _____

Psychiatrist's Statement: Please answer the following questions. Please check yes or no.

- Is the student unable to attend school for a minimum of 10 consecutive days? Yes ☐ No ☐
- Is the student confined to the home or hospital? Yes ☐ No ☐
- Are full time HHB services recommended? Yes ☐ No ☐
- The student who has a chronic or long term illness and who will be absent from school ten days in the year may receive *intermittent HHB services rather than full time HHB services. Is this an option for the student? Yes ☐ No ☐
- Can instruction be provided without endangering the health or safety of the instructor Yes ☐ No ☐
- Can this student come into contact with other students? Yes ☐ No ☐
  or other students with whom the instructor may come in contact?
- Does the student have a communicable disease? Yes ☐ No ☐
- Is the student able to participate in and benefit from an instructional program? Yes ☐ No ☐

***If student is approved for intermittent HHB services, medical updates will be required on a schedule defined within the Student's Educational Service Plan (ESP**

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Medical Certification Form for Psychiatric Diagnosis
Treatment and School Re-entry Plan

The following information is required to determine eligibility for Hospital-Homebound instruction and must be completed by the licensed psychiatrist who is currently treating the student for the diagnosis presented.

What is the treatment/therapy schedule for this student? Daily _____ Weekly _____ Monthly _____

What is the expected duration of the treatment/therapy? _____

Could the student return to school on an intermittent basis after his/her medication or condition is stabilized? If applicable, please explain below.

Will the student take medication? YES_____ NO_____. If yes, please list the medications below:

List of Medications

Name of Medication	Effects on student's ability to comprehend	Effects on student's ability to complete independent assignments	Effects of student's ability to relate to teachers and other students

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Medical Certification Form for Psychiatric Diagnosis
Treatment and School Re-entry Plan

Please indicate any limitations or restrictions during HHB instruction, including medication effects.

Hospital-Homebound (HHB) instruction is offered as a support service; it is designed to provide temporary instructional assistance to students who are unable to physically attend school for medical or psychiatric. HHB is not intended to replace regular classroom instruction. A maximum of eight weeks of HHB support is provided to students with psychiatric diagnoses. All students are encouraged to return to school as soon as possible. Below, please describe **(or attach**) your time frame and transitional plan for the student's re-entry to school

Psychiatrist's Certification

With the understanding that the Hospital/Homebound Program is the most restrictive educational environment, I certify that this student is under my care and treatment for the aforementioned medical condition and, in my professional opinion, it is medically necessary to place this child in this very restrictive educational environment

_____ _____ _____
Psychiatrist's Signature ***GA License Number*** ***Date***

***PLEASE NOTE**: If form is completed by a PA or ARNP, the name, signature, and phone number of the supervising psychiatrist is required below:

Supervising Physician Name (Printed) _____

Physician's Designee Name (Printed) _____

Phone number of Supervising Physician: _____ Fax number: _____

Specialty: _____, _____, _____

Signature of Supervising Physician _____Date _____

Signature of Physician's Designee _____Date _____