FAX #: 678-827-8096 Fax to ATTN: Dr. Quintella Harrell

CLAYTON COUNTY PUBLIC SCHOOLS
Hospital-Homebound Department
1588 Lovejoy Road – Hampton, Georgia 30228
Phone: 678-817-3119 Cell: 678-977-3751 Fax: 678-827-8096

Medical Certification Form

Incomplete medical certification forms cannot be approved for Hospital-Homebound services.

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 physician or licensed psychiatrist who is treating the student for the presenting diagnosis. To be considered eligible for HHB instructional services, the student's attending physician/psychiatrist anticipates student absences for a minimum of ten consecutive school days for acute illness, injury, or surgery, and anticipates intermittent absences at a minimum of ten school days per year for the chronically ill students. (HHB rule 160-4-2-.31)

Please type or print and return to the Hospital-Homebound Department

Name of Student: _____ Age: _____DOB: _____

Name of Physician/Psychiatrist: _____

Phone: _____ Fax: _____

Address: _____

Date of Examination: _____ Date of Next Examination:_____

Diagnosis: _____

Length of Time Student Will Need HHB Instruction:

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

Physician's/ 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 or other students with whom the instructor may come in contact? **Yes☐ No☐**
- 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, a 504 Plan or IEP must be in place and additional medical update(s) will be requested on a schedule defined within the Student's Educational Service Plan (ESP).**

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Student's Name: _____ ID#:_____ DOB: _____

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

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 physician or 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.

Hospital-Homebound instruction is offered as a support service; it is not intended to replace regular classroom instruction. Therefore, students are encouraged to return to school as soon as possible. Please describe your time frame and transitional plan for the student's re-entry to school

Physician's Certification

I certify that this student is under my care and treatment for the aforementioned medical condition. My recommendation has been based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.

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

For HHB Department Use Only

HHB Instructor: _____ Date Completed Form Received: _____

Date Physician Contacted: _____Comments: _____