Hospital/Homebound (HHB) Application

Medical Referral & Certification Form

Hall County Schools

711 Green Street Gainesville, GA 30501 (770) 534.1080 Fax: (770) 533.4015

Student Name _____ School: _____

*****Must be completed by a physician or psychiatrist licensed by the State of Georgia. Incomplete information may delay services.***

Print Physician's/Psychiatrist's Name _____GA License #_____

Address_____ Phone Number_____

Parent/Guardian Agreement/Release for Medical Information:

I have read the Hospital/Homebound policies for program eligibility and I understand the reasons for possible dismissal from the program. I agree to the policies and requirements of the program and request Hospital/Homebound services for my child. I hereby give permission for the attending licensed physician or licensed psychiatrist for the diagnosis presented to communicate information regarding my child's medical/emotional condition for which he/she is referred.

X_____ _____

Parent/Guardian Signature Date

Part A. Physician/Psychiatrist Statement and Diagnosis

Patient's Diagnosis/Prognosis (Include a description of the condition) _____

_____

_____

Date student may **begin** HHB services _____ **Date** student will **return** to school: _____

***Due to scheduling purposes, do not list unknown or undetermined. If the medical condition extends into next school year, a new application must be submitted.

If pregnant EDC: _____

Date of initial evaluation_____ Date of next scheduled appointment_____

Physician's Statement: Please answer the following questions.

- Is the student unable to attend school for a minimum of 10 consecutive school days Yes____ No____
- Will the student be able to benefit from an instructional program during this time of confinement? Yes____ No____
- Could the student attend school with accommodations? If so, describe. Yes____ No____

Recommendations for accommodations_____

_____

_____

- Could the student attend school regularly and receive Hospital/Homebound services on an intermittent basis, as needed? *(Intermittent is designed for students with chronic or long term illness (e.g. CA) who will be absent for treatment or appointments 3 or more days at a time for greater than 10 total during the school year).* Yes____ No____
- Is the student confined to home or hospital and full time Hospital/Homebound services are recommended? Yes____ No____
- Is the student free from communicable disease? Yes____ No____
- Can instruction be provided to the student without endangering the health of the instructor or other students whom the instructor may contact? Yes____ No____

Part B. Treatment and School Re-entry Plan

The following information is required to determine eligibility for Hospital/Homebound services 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? _____
- Will the student take medication? Yes____ No____

Hospital/Homebound Referral & Certification Form

Student Name: _____ School :_____

Please complete the following information for each medication that the student will take

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

Treatment and Re-entry Plan

- Could this student return to school after his or her medication and condition are stabilized? Yes___ No____
- Can this student come into contact with other students? Yes___ No____

The Hospital/Homebound program is designed to be a *temporary educational program* to help children who are unable to attend school for medical or psychiatric reasons. Please describe your ***time frame and transitional plan for the student's re-entry to school***: (Attach additional sheets as needed)_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.

_____ _____

LICENSED Physician's Signature Date

Stamp: