The School District of Osceola County, Florida

Office of Exceptional Student Education

Hospital/Homebound (H/H) Request

Section I: Student information and Release of Information (to be completed by parent/legal guardian)

Student ID#	Student First Name	MI	Last	Birth Date	Date of Report

Grade	Current School	Parent/Legal Guardian Name

Parent/Legal Guardian E-Mail Address	Parent/Legal Guardian Preferred Phone #	Alternate Phone#

Parent/Legal Guardian Address	City	State	Zip Code

Authorization for Release and Exchange of Information

I hereby authorize the student's physician(s) to release all information concerning diagnoses, treatment plan, medical implications or instruction, and reentry plan to the School District of Osceola County. This communication may be written or verbal. This release will remain in effect until the student has been dismissed/discontinued from the Hospital/Homebound program.

_____ _____

Parent/Legal Guardian Signature Date

Checklist of responsibilities of parent/guardian

Please initial next to each statement indicating you have read the following regarding parental responsibilities in the Hospital/Homebound request process:

_____ I understand that before Hospital/Homebound services can be provided, my child must be enrolled in an Osceola County Public School; it is my responsibility to request enrollment.

_____ I understand that it is my responsibility to first follow-up with the doctor's office to confirm their completion and submission of the Hospital/Homebound Medical Information form, and second to call the Hospital/Homebound office to confirm that the completed form has been received.

_____ I understand that it is my responsibility to continue requesting and submitting completed assignments/makeup work, until the child is withdrawn from the school as grades will transfer with the student.

_____ I understand that if my child is too ill to attend school, I must continue to report absences to the school, per district policy, until an eligibility meeting and I give official written consent for instruction through the Hospital/Homebound Program.

_____ I understand this request does not guarantee placement in the Hospital/Homebound Program.

_____ I understand that state eligibility criteria for Hospital/Homebound services require that the child be **confined** to the home or hospital. The only exception is if the student is co-enrolled with a school site.

_____ I understand 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.

_____ I understand the Hospital/Homebound Program CANNOT duplicate the hours or all courses provided at a school site.

_____ I understand the Hospital/Homebound Program follows the school district calendar. This includes student holidays/breaks, marking periods, and report card distribution.

To be completed by school only.

DATE RECEIVED

_____/_____/_____

MM DD YY

Student ID#	Student First Name	MI	Last	Birth Date	Date of Report

Section II: Physician Contact Information (to be completed by Physician)

Physician Name	Area of Practice	License Number	Licensing State

Address	City	State	Zip Code

Physician E-Mail Address	Physician Phone #	Fax #

Section III: Medical Information & Certification (to be completed by the treating physician)

Information must be printed. If completed by a licensed ARNP or P/A, the name of the licensed supervising physician must be noted on page 3.

The student mentioned above is being considered for hospital/homebound instructional services based on a medical or psychiatric diagnosis **confining** the student to the home or hospital. Please complete the form below providing details regarding the medical diagnosis to assist us in making appropriate educational decisions. Please keep in mind, hospital/homebound services are limited and basic in nature. Our goals are to minimize instructional gaps by providing temporary access to academic curriculum while the student is medically **confined** and to promote reentry into a traditional school setting.

Date of Onset of Condition	Date Last Seen by Physician

Please indicate the student's diagnosis (no ICD9 codes) that prohibits your patient from attending school.

Nature of **Confinement**: Explain in detail how the medical or psychiatric condition you have diagnosed significantly limits the student from receiving an education at the regular school setting (to what degree is the student **confined** to the home/hospital).

Provide a description of the treatment plan including current therapies/treatments and medications. Include information regarding how the treatment plan components may interfere with participation in hospital/homebound instruction (i.e. side effects, schedule of services).

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What are your recommendations for school re-entry and other school-related activities?

Required from Physician: Provide an estimated duration of the condition or prognosis.

Required from Physician: Provide recommended dates for confinement to the home or hospital:

Beginning of Confinement: _ _____/_____/_____ End of Confinement: _____/_____/_____ (date of return to school)
Month Day Year Month Day Year

**Please note: a referral cannot exceed one calendar year. If this section is left blank, it will delay the process of this request.*

Required from Physician: The student is recommended to be confined to the home or hospital as checked below: (Check only one option)

☐ Intermittently: Student can attend school at a school site most school days; may be ill occasionally.

☐ Partial Day: Student can attend school part of every day during a recuperative period of readjustment to a full day.

If eligible, how many hours should the student be able to attend school? _____

☐ Full-Time: Student is not able to attend school at a school site due to the need for full time confinement.

If eligible, how many hours of hospital/homebound schoolwork should this student be able to endure each day?
Please check one:

☐ 7 hours ☐ 6 hours ☐ 5 hours ☐ 4 hours ☐ 3 hours ☐ 2 hours ☐ 1 hour

☐ None of the Above: Student can attend school full time.

Medical Certification All questions must be answered by the physician	Initial below to indicate a response of "Yes" or "No"	
	Yes	No
Is the student expected to be absent from school due to the medical condition for at least fifteen (15) consecutive days, or absent due to a chronic medical condition for at least fifteen (15) non-consecutive days.		
Will the student be **confined** to the home or hospital during the time hospital/homebound services are expected?		
Will the student be able to participate in and benefit from an instructional program provided through a hospital/homebound program?		
Is the student under medical care for the illness or injury that is **acute, catastrophic, or chronic in nature?**		
Can the student receive hospital/homebound instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact with?		
Is the student able to go to a school site to take standardized/semester assessments?		

Physician's Signature:_____ Date: _____

****Signature Required (Stamp NOT Accepted)**

A "licensed physician" means one who is qualified to assess the student's physical or psychiatric condition (M.D. or D.O.). An ARNP or PA working for a physician licensed under the authority of sections 458 or 459, F.S., may sign this medical statement instead of the physician. The name of the licensed physician must be noted on the statement in addition to the signature.

Please Print Supervising Physician and Title _____ Phone Number _____
Supervising Physician Signature _____