Alachua County Public Schools, 620 E. University Avenue, Gainesville, FL 32601
Exceptional Student Education

Hospital/Homebound Medical Certificate: Physical/Psychiatric Condition

Florida State Board of Education Rule 6A-6.03020, F.A.C., requires an annual medical statement/report from a licensed physician in order for the student to be considered for the Hospital/Homebound program. A licensed physician is one who is qualified to assess the student's physical or psychiatric condition. In order for Alachua County Public Schools to receive this information, a release of information is required.

Section I: Release of Information – to be completed by the parent/guardian

Student Name			Date of Birth		Date of Request
Grade	School	Parent Name		E-Mail Address	
Address		City	Zip Code	Phone #	Alternate #

I hereby authorize the physician(s) to release all information concerning diagnoses, treatment plan, and medical implication for instruction and re-entry to Alachua County Public School. This release will remain in effect until the student has been dismissed from the Hospital/Homebound Program. ***Must be signed by parent/guardian or student at the age of majority.***

Parent /Guardian Signature: _____

Section II: Physician/Psychiatrist Contact Information- to be completed by parent/guardian

Physician/Psychiatrist Name	Area of Practice	Phone #	Fax #
Physician/Psychiatrist Address	City	Zip Code	
Physician/Psychiatrist E-Mail Address			

Parent is to complete sections 1 and 2 and bring to Physician/Psychiatrist office in order for Medical Certificate to be completed. Physician Psychiatrist's office will complete Sections III and IV, Email to ESEhospitalhomebound@gm.sbac.edu The Hospital/Homebound Office will contact parent within two business days of receiving Medical Certificate.

Section III: Medical Certificate – to be completed by a Florida Licensed Physician/Psychiatrist

Completion of this form is required as part of the eligibility process and does not guarantee placement in the Hospital/Homebound Program. Failure to complete this form in its entirety and return it in a timely manner may result in delay of eligibility determination.

Please note that Hospital/Homebound Services (HHB) do not duplicate the comprehensive classroom experience. The intention of HHB is to keep the students as current as possible in their required courses, with the priority being the student's health care needs. HHB services should be viewed as a temporary intervention and is not intended to replace the classroom experience.

Onset Date:	**Date Last Seen by Physician/Psychiatrist:**	**Expected School Return Date** (mandatory)

Medical Condition: *Describe the condition(s) which confines the student to home or hospital. Attach additional documentation if necessary. As per rule: 6A-6.03020, a hospital/homebound student is a student who has a diagnosed medical or psychiatric condition which is acute in nature, or a chronic illness, or a repeated intermittent illness due to a persisting medical problem and which confines the student to home or hospital , and restricts activities for an extended period of time.*

Medical Implications for Instruction: *Included skills deficits, side effects, behavior changes, difficulties, etc.*

Treatment Plan and other information: *State Requirement* (Check all that applies)

- ☐ Medication Management
- ☐ Surgical Management
- ☐ Post-surgical Recovery
- ☐ Frequent medical monitoring and follow-up
- ☐ Bed Rest
- ☐ Chemotherapy
- ☐ Psychotherapy
- ☐ Dialysis
- ☐ Hospitalization
- ☐ Other (explain below)

Recommendation for School Re-entry: *Include participation in school related activities, physical education, etc.*

Estimated Duration of the condition or prognosis: *Specify the number of days, weeks, or months the students is expected to require services through the Hospital/Homebound Program. This medical report cannot exceed 12 month and must be updated annually.*

Section IV: Medical Statement – Completed by the Florida Licensed Physician/Psychiatrist

All questions must be answered and initialed by the Physician/Psychiatrist.

Yes	No	Initials	
☐	☐	_____	Is the student expected to be absent from school for at least 15 consecutive days, or due to a chronic condition for at least 15 school days which need not run consecutively.
☐	☐	_____	Is confined to home or hospital? (Please see the confinement levels for the purposes of instruction below)
☐	☐	_____	Will the student be able to participate in and benefit from an instructional program?
☐	☐	_____	Is the student under medical care for an illness of injury that is acute, catastrophic or chronic in nature?
☐	☐	_____	Can the student receive instructional services without endangering the health and safety of the instructor or other students with who the instructor may come in contact with?

Confinement Level: *the physician/psychiatrist must certify that the student is unable to attend school. Based on your examination, which level of confinement do you recommend for consideration?*

- ☐ Full-time Hospital/Homebound- Student is **unable** to attend any portion of the school day
- ☐ Part-time Hospital/Homebound Student is **able** to attend school part day for _____hours a day.
- ☐ Intermittent Hospital/Homebound Student is currently able to attend school; however, it is expected that they will experience intermittent days of hospitalization or home confinement.

Medical Provider Signature: Signature must be an original. Reproduction such as a stamp will not be accepted.

_____	_____	_____
Print Name of Physician/Psychiatrist- *MD/OD Required*	Signature of Physician/Psychiatrist	Date

Scan and Email: ESEhospitalhomebound@gm.sbac.edu