Physicians

The referral form must be completed in its entirety.

Students that are confined to the home or hospital may be eligible to receive educational services through the Homebound/Hospitalized Program. By completing this referral, in its entirety, you, as the physician/psychiatrist are indicating that the student is undergoing medical treatment by you for an *illness or injury which is acute, catastrophic, or chronic in nature,* and is expected to be absent from school due to this described illness or injury. (6A-6.03020)

Please note that referral forms with omitted fields will not be processed. Forms are available at the following location:

Exceptional Student Education
St Lucie Public Schools
9461 Brandywine Lane
Port St. Lucie, FL 34986

For additional information, please contact:
Lewis Hinton at 772-429-3600

Completed referrals can be faxed to the Exceptional Student Education office at: 772-429-4528

Criteria for Eligibility

A student, who is hospitalized or homebound, is eligible for specially designed instruction if **ALL** of the following criteria are met:

1. Is expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) consecutive school days or the equivalent on a block schedule, or due to a chronic condition, for at least fifteen (15) school days or the equivalent on a block schedule, which need not run consecutively **and**;
2. Is **confined to the home or hospital and;**
3. Will be able to participate in and benefit from an instructional program **and**;
4. Is under medical care for illness or injury which is acute, catastrophic, or chronic in nature **and**;
5. Can receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact **and**;
6. The student is enrolled in a public school in kindergarten through twelfth grade (K-12) or a Pre-K exceptional education student. These referral forms are available through the District Exceptional Student Education Office or the Guidance Counselor at the student's assigned school **and**;
7. A parent/guardian or primary care giver signs parental agreement concerning hospitalized or homebound policies and parental cooperation

Procedures for Determining Eligibility

A. The minimum evaluation to determine eligibility shall be an ANNUAL medical report from a licensed physician. This report shall include **ALL** of the following:
   1. A description of the disabling condition or diagnosis with any medical implications for instruction and;
   2. A statement by the treating doctor that the student is unable to attend school and;
   3. A description by the treating doctor of the plan of treatment and;
   4. Recommendations by the treating doctor regarding school re-entry and other school-related activities and;
   5. An estimated duration of the condition or prognosis made by the treating doctor.

B The completed Homebound/Hospitalized referral must be faxed to the Homebound/Hospitalized Office at 772-429-4528.

C. An eligibility meeting is scheduled at the student's assigned school.

D. An IEP (individual educational plan) or IFSP (individualized family support plan) is developed or revised prior to assignment to the Homebound/Hospitalized Program and to a school based program due to an acute, chronic, or intermittent condition.

E. The parent, guardian, or primary care giver must sign parental agreement concerning Homebound/Hospitalized policies and parental cooperation.

Dismissal from the Homebound/Hospitalized Program

Prior to returning to school the following **must** occur:

1. A doctor's permission to return to school (Doctor's Release Form) must be completed by the doctor. This form is available from the Homebound/Hospitalized Office or school guidance counselor.
2. Parents must fax a copy of the Doctor's release to the student's assigned school.
3. A dismissal or staffing will be scheduled with the student's assigned school.

A student **may** also be dismissed from the Homebound/ Hospitalized Program for the following reasons;

1. Medical eligibility expires
2. The student is no longer confined to the hospital or home
3. Failure to keep scheduled appointments in which case an IEP meeting will be scheduled to include a Program Specialist from the Homebound/ Hospitalized Program, teachers, parents, and student to discuss excessive absences or other matters that occur.

General Responsibilities

The **parent/guardian or primary caregiver** shall commit to the following:

1. Ensure the student's activities are restricted to the home or hospital
2. Provide a quiet, clean, well ventilated setting where the teacher and student will work.
3. Ensure that a responsible adult is present whenever a teacher is providing in-home instruction.
4. Establish a schedule for student study between teacher visits.
5. Have the student ready for homebound services at the scheduled time.
6. Notify the homebound teacher immediately, but no later than two (2) hours prior to a scheduled instructional session, if the student is unable to keep the scheduled time.

Attendance

Due to strictly enforced attendance policies, credit for courses may only be awarded when minimal contact hours have been met. If your child misses a class due to a medical appointment, it is your responsibility to obtain a doctor's note verifying your child was seen in the doctor's office that day. This note should be given to the Homebound/Hospitalized contact. Students enrolled in the Homebound/Hospitalized Program are expected to be in class. Unreported absences will result in an unexcused absence for the class. Absences must be reported by the parent/guardian to the Homebound/Hospitalized teacher in advance.

Incomplete forms will not be processed-all fields must be completed

St. Lucie Public Schools

Exceptional Student Education

REQUEST FOR CONSIDERATION FOR HOMEBOUND/HOSPITALIZED SERVICES

SECTION 1 – COMPLETED BY THE PARENT/GUARDIAN

Please provide all requested information**. There may be a delay in processing incomplete applications.**

**** A NEW HOMEBOUND/HOSPITAL REFERRAL IS REQUIRED EACH SCHOOL YEAR**

Student Name_____ D.O.B._____ Gender: _____
Last First Middle

Address _____
Street City Zip Code

Parent/Guardian(s) Name_____ Phone: Home _____
Last, First, Middle Work _____

Parent email_____ Cell _____

School_____ Student ID#_____

I hereby authorize the physician to release all information concerning diagnosis, treatment and any medical implications for instruction to the School District of St. Lucie County. This communication may be written or verbal. This release will remain in effect until the student has been dismissed from the Homebound/Hospitalized Program.

Must be signed by parent/guardian or student at the age of majority (18 years orolder) _____
SIGNATURE OF PARENT/GUARDIAN OR STUDENT AT THE AGE OF MAJORITY

SECTION 2 – COMPLETED BY THE PHYSICIAN/PSYCHIATRIST

Incomplete forms will not be processed-all fields must be completed

Date of Referral _____

Physician/Psychiatrist Name_____ Specialty _____

Physician/Psychiatrist Address_____ Telephone _____

Fax Number _____

EXPECTED DATE OF RETURN: If an **undetermined** date is indicated, the form will be **returned** to the physician and/or psychiatrist for an expected date of return. Returned forms will delay the student's possible placement into the Homebound/Hospitalized Program. If during treatment the physician/psychiatrist needs to extend the expected date of return to school, the physician/psychiatrist may do so by completing a new Homebound/Hospitalized referral form

Date of Referral_____ Last Visit Date_____ **Expected School Return Date (mandatory)** _____

Incomplete forms will not be processed-all fields must be completed

Condition: Describe the disabling condition or diagnosis (attach additional sheets if necessary)

_____

_____

_____

_____

_____

ELIGIBILITY: The licensed physician/psychiatrist must certify that the student meets all of the following criteria for eligibility. Students who do not meet all of the minimum eligibility criteria listed below will not be eligible for Homebound/Hospitalized Services. **All questions must be answered by the physician/ psychiatrist.** Please be as specific as possible.

1. Could the student attend school with accommodations? If so, please describe. (*e.g. second set of books at home or a wheelchair, etc.*) **Yes** _____ **No** _____

Recommendations: _____

2. Could the student attend school regularly and receive Homebound/Hospitalized services on an intermittent basis as needed? (attend school when able and receive HH when ill) **Yes** **No** _____

3. Could the student attend partial days at school? **Yes**_____**No** _____

4. Is the student expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) school days or the equivalent on a block schedule? **Yes**_____**No** _____

5. Is the student **confined** to the home or hospital? **Yes**_____**No** _____

6. Will the student be able to participate in and benefit from an instructional program? **Yes**_____**No**_____

7. Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature? **Yes**_____**No** _____

8. Can the student receive instructional services without endangering the health and safety of the instructor or other students the instructor may come in contact? **Yes**_____**No** _____

9. Do you recommend the student be placed in this most restrictive environment? **Yes**_____**No** _____

***Students entering the Homebound/Hospitalized Program will be placed in the <u>most restrictive</u> educational and social environment where the student will NOT have physical contact with their peers during the school day.**

Treatment Plan

Treatment and School Reentry Plan: *The following information is required to determine eligibility for Homebound/Hospitalized services and must be completed by the treating physician/psychiatrist.*

1. What is the therapy schedule for this student? Will it interfere with Homebound/Hospitalized instruction?
   Daily_____ **Weekly**_____ **Monthly**_____

2. Expected duration of treatment/therapy? _____

3. Will the student be taking medication? **Yes**_____ **No** _____

Incomplete forms will not be processed-all fields must be completed

4. Name(s) of medication _____

- Effects on student's ability to comprehend instruction. How _____
- Effects on student's ability to complete independent assignments. How _____
- Effects on student's ability to relate to teachers and other students. How _____

5. Could this student return to school on an intermittent basis after his/her or medication and condition are stabilized? **Yes**_____ **No** _____

6. Can this student come into contact with other students? **Yes**_____**No** _____

7. The Homebound/Hospitalized 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 pages asneeded*)

_____

_____

_____

Duration of absence from regular school is expected to be:____weeks **or**_____months (maximum 1 school year)

Recommended Placement: _____Homebound/Hospital only: **or**
_____Co-enrollment between School and Homebound/Hospitalized

Remarks: _____

Physician's/Psychiatrist's Certification: I certify that this student is under my care and treatment for the aforementioned illness. My recommendation has been made based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.

_____ _____

Physician's/Psychiatrist's Signature and Title* *Date*

Phone: _____

Address: _____

City, State, Zip Code: _____