Manatee County Schools Exceptional Student Education

REFERRAL FOR HOSPITAL HOMEBOUND INSTRUCTION

PLEASE RETURN COMPLETED FORMS TO:

STUDENT'S HOME SCHOOL:

GUIDANCE COUNSELOR:

FAX#: PHONE#:

CRITERIA FOR ELIGIBILITY:

1. Student has a medically diagnosed physical or mental condition, which confines the student to home or hospital for at least fifteen (15) days. The days DO NOT need to be consecutive.
2. Parent or guardian/hospital administrator signs parental agreement concerning Hospital Homebound policies and parental cooperation.
3. Physician provides a medical statement describing the handicapping condition and estimated duration of the condition and certifying that the student can receive an instructional program without endangering the health of the instructor or other students with whom the instructor may come in contact.
4. The student must be able to participate in and benefit from an instructional program.

THERE IS NO WAITING PERIOD TO APPLY FOR HOSPITAL HOMEBOUND SERVICES.

- The Hospital Homebound program is designed to provide instruction focusing on current academic objectives.
- **HOSPITAL HOMEBOUND IS NOT RESPONSIBLE FOR WORK ASSIGNED PRIOR TO ENROLLMENT IN THE HOSPITAL HOMEBOUND PROGRAM. THE PARENT WILL MAKE ARRANGEMENTS TO PICK UP AND RETURN ALL MISSING WORK UNTIL THE STUDENT IS DETERMINED ELIGIBILE AND PLACED ON HOSPITAL HOMEBOUND.**

GUIDANCE COUSELOR RESPONSIBLITES:

Complete/Print the Consent for Evaluation Form in PEER (must have parent signature and date)
Does the student meet the criteria listed above?
Make sure the student is enrolled in your school and has an active schedule.
Have parent sign and date the Physician's Section and the Parent/Guardian Agreement page.
On the second page of the Physician's Section, fill in your name and contact information before giving to parent.

ONCE THE COMPLETED PHYSICIAN'S SECTION AND PARENT/GUARDIAN SECTION IS RETURNED TO YOU:

Print the ESE screen from Focus. (If the student is ESE)
Print the Address screen and the Demo screen from Focus.
Complete the Hospital Homebound Student Registration Form.

CHECKLIST BEFORE SENDING TO HOSPITAL HOMEBOUND:

PRINTED CONSENT FOR EVALUATION FORM WITH PARENT SIGNATURE AND DATE.
PHYSICIAN'S SECTION (CHECK FOR PARENT SIGNATURE AND DATE)
PARENT/GUARDIAN AGREEMENT PAGE (CHECK FOR PARENT SIGNATURE AND DATE)
PRINTED FOCUS SCREENS
HOSPITAL HOMEBOUND STUDENT REGISTRATION FORM

SCAN OR EMAIL TO: STOUTB@MANATEESCHOOLS.NET OR FAX TO: (941)751-7376

SCHOOL BOARD OF MANATEE COUNTY HOSPITAL/HOMEBOUND INSTRUCTION

SECTION III: TO BE COMPLETED BY PARENT/GUARDIAN

I request Hospital Homebound instruction for(student's full name). I understand that this is a **temporary educational program** and that the amount of instruction and course offerings are significantly less than those provided by the regular school. My child will continue to **attend public school** and **complete all assignments** until I have been notified that they have been placed in the Hospital Homebound program. **I will make arrangements to pick up and return all missing work to the child's home school until they are determined eligible and placed on hospital homebound. I** request, upon meeting eligibility requirements, that this student be placed in the Hospital Homebound Program. I have read and agree to the following conditions below.

FAILURE TO COMPLY WITH THIS AGREEMENT MAY RESULT IN THE STUDENT'S DISMISSAL FROM THE HOSPITAL/HOMEBOUND PROGRAM.

Parent Signature **Date** **Phone Number**

Parent Email Address **Student Email Address**

* Hospital Homebound is **not a full-time program** and is **not designed as an alternative to regular school attendance. Schedules may be reduced and some courses may not be offered.**
* **Hospital Homebound is not responsible for work assigned prior to enrollment in the Hospital Homebound program. The parent will make arrangements to pick up and return all missing work to the child's home school until they are determined eligible and placed on hospital homebound.**
* A daily study schedule for the student must be established by the parent. The parent will provide the necessary supervision for the student to complete assignments. **THE RESPONSIBILITY FOR COMPLETING ASSIGNMENTS WILL REMAIN WITH THE STUDENT.**
*If the student will remain in the program beyond the duration date specified by the physician, the parent/guardian must provide a statement from the physician with the extension date and reason for extension in order for the student to remain in the Hospital Homebound program.
* Grades will be based on homework, daily work, and/or tests. Grades will be issued by the homebound teacher at the end of the grading period and/or when a student is withdrawn from the program. Grades for a partial grading period will be averaged with those grades received at the home school for the final grade. The district grading scale will be followed.
* **A <u>responsible adult, eighteen (18) years or older, must be present</u> in the home If a teacher is present. If the attending adult must leave the home during a session, the teacher must also leave.**
* A clean, well-ventilated, quiet work setting must be provided.
* All visitors, pets, siblings, and children will be kept out of the room during instructional time with a teacher.
* Books, pencils, paper and other materials must be ready for each instructional/testing session.

***Cancelled appointments will impact my child's progress, and it is important that my child attend all instructional appointments. In case of an emergency, I (parent/guardian only) agree to contact the Hospital Homebound teacher to cancel home instruction appointments, at least 3 hours, prior to the scheduled instructional time.**

* If the student becomes ill with a **communicable or contagious disease,** the parent/guardian must notify the homebound teacher **to reschedule the visit.**

PROGRAM DISMISSAL MAY BE RECOMMENDED BASED ON ANY OF THE FOLLOWING:

*The student fails to keep physician or psychiatric appointments.

*The student is employed, goes on vacation, participates in extracurricular activities, or is no longer confined to the hospital or home.

*The student fails to attend enough to benefit from instruction or is too ill to benefit from instruction. **The student does not participate in instruction or complete assignments.**

*The student has excessive absences, non-attendance, or failure to keep scheduled appointments.

ADMINISTRATOR OF ESE SIGNATURE:

SCHOOL BOARD OF MANATEE COUNTY FLORIDA
EXCEPTIONAL STUDENT EDUCATION REQUEST FOR CONSIDERATION OF HOSPITAL/HOMEBOUND INSTRUCTION

A homebound or hospitalized student is a student who has a medically diagnosed physical or psychiatric condition which is acute or catastrophic in nature, or a chronic illness, or a repeated intermittent illness due to a persisting medical problem and that confines the student to home or hospital and restricts activities for an extended period of time. The corresponding definition is found in State Board of Education Rule 6A-6.03020, Florida Administrative Code (FAC).

SECTION I - COMPLETED BY THE PARENT/LEGAL GUARDIAN

I hereby authorize the student's physician(s) to release all information concerning diagnosis, treatment and any medical implications for instruction to the School District of Manatee County. This communication may be written or verbal. This release will remain in effect until the student has been dismissed from the Hospital/Homebound Program or at the end of the school year.

Must be signed by parent/legal guardian **or student at the age of majority** (18 years or older).

Signature

Date

SECTION II - COMPLETED BY THE LICENSED PHYSICIAN/PSYCHIATRIST (LICENSED BY THE STATE OF FLORIDA)

STUDENT NAME (FIRST LAST)	BIRTHDATE MM/DD/YYYY	
PHYSICIAN/PSYCHIATRIST NAME	SPECIALITY	
ADDRESS	CITY	ZIP
PHONE	FAX	

ALL QUESTIONS MUST BE ANSWERED BY THIE PHYSICIAN IN ORDER TO CERTIFY ELIGIBILITY FOR HOSPITAL/HOMEBOUND INSTRUCTION. "NOT APPLICABLE", "UNKNOWN", AND "UNDETERMINED" AND/OR MISSING INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.

	YES	NO	
1.			Is the student under medical care by a **licensed physician or psychiatrist** for an illness or injury which is acute, catastrophic, or chronic in nature?
2.			Is the student expected to be absent from school due to a **physical or psychiatric condition** for at least **15** consecutive school days, or due to a **chronic condition,** for at least **15** school days which need not run consecutively?
3.			Is the student **confined** to the home or hospital?
4.			Is the student well enough to **participate in and benefit from** an instructional program?
5.			Can the student receive instructional services **without endangering the health and safety** of the instructor or other students with whom they may come in contact with?
6.			**Can accommodations** be provided by the home school **instead of the student being placed on hospital homebound?** Please list accommodations:

RECOMMENDED SERVICE DELIVERY MODEL (please select only one below)

	Full-time Hospital/Homebound - Student is UNABLE to attend ANY portion of the school day. This is the most restrictive educational and social environment where the student will have no physical contact with his or her peers during the school day.
	Intermittent Hospital/Homebound - Student is ABLE to attend school full time until the health condition interferes. Hospital homebound acts as a support or intervention only when needed.
	Part-time - Student is able to attend school for a partial day/week. Specify times/days:

PHYSICIAN'S TREATMENT PLAN

FLORIDA STATE BOARD RULE 6A-6.03020 **REQUIRES THE FLORIDA LICENSED** PHYSICIAN(S) TO DESCRIBE THE **PLAN OF TREATMENT AND PROVIDE RECOMMENDATIONS FOR SCHOOL RE-ENTRY.** PLEASE COMPLETE THE FOLLOWING: **("NOT** appl icabl e", **"UNKNOWN", AND "UNDETERMINED" AND/OR MISSING INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.)**

Please indicate the student's **medical diagnosis** including a **description** of the handicapping condition:

Explain in detail how the physical **or** psychiatric condition you have diagnosed will **significantly limit** the child's ability to receive educational benefit in the **regular school setting.** In what way(s) would the child's ability to function in the school setting be jeopardized?

Describe your **treatment plan** for the child (include the **frequency and duration of the treatment** for psychiatric conditions).

List any **medication(s)** the child is taking and explain the **effects,** if any, the medication(s) may have on the child's ability to achieve educational benefit in the school setting.

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. The amount of instruction provided by the Hospital/Homebound Program is significantly less than that provided by the regular school setting. Providing a re-entry date is mandatory, however, it may be extended by the physician. Given this, **indicate the date** this student will reenter his/her district assigned school:

RE-ENTRY DATE:

MM/DD/YYYY

(Date the student will return to school **WITHOUT** Hospital Homebound services.)

PHYSICIAN'S CERTIFICATION: I certify that this student,(student's full name),
is under my care and treatment for the diagnosis listed above. My recommendation has been made on the medical needs of the patient, keeping in mind that the **least restrictive setting is mandated by federal law.**

This certifies that this treatment plan is medically necessary. Date of Evaluation:

(PRINT) PHYSICIAN'S NAME **PHYSICIAN'S SIGNATURE**

IF AN ARNP OR PA SIGNS ABOVE, THE NAME/PHONE NUMBER OF THE SUPERVISING PHYSICIAN IS REQUIRED BELOW.

SUPERVISING PHYSICIAN'S NAME **SUPERVISING PHYSICIAN'S PHONE #**

PLEASE SUBMIT TO GUIDANCE COUNSELOR:(name)

School Name:Fax#

HOSPITAL HOMEBOUND STUDENT REGISTRATION FORM

Student: Grade:

School: Date:

List classes identified by the IEP team.

** If found eligible, students who are placed on Full Time Hospital Homebound will be switched from an AP or Honors course to a regular education course. A student can resume their AP or Honors course as soon as they return to their home school. **

Elementary & Middle Schools:

Course Name	Course Number	Withdrawal Grade	**Regular Ed Course Code if taking an AP or Honors Couse**

High Schools:

Semester 1

Course Name	Course Number	Withdrawal Grade	**Regular Ed Course Code if taking an AP or Honors Couse**

Semester 2

Course Name	Course Number	Withdrawal Grade	**Regular Ed Course Code if taking an AP or Honors Couse**