

Home/Hospital Instruction Request Form

PHYSICIAN CERTIFICATION FOR HOME/HOSPITAL SERVICES

Some students need adjustments to their educational school program due to medical, physical, or psychiatric conditions. In these unique instances, educational instruction may be provided in the home, hospital, or treatment center. These instructional sites do not replicate actual classrooms and instruction is not a comparable alternative to daily classroom instruction. Please complete this form for your patient who meets these distinctive conditions.

AN UPDATED MEDICAL REFERRAL WILL BE REQUIRED EVERY 30, 60, OR 90 DAYS DEPENDING ON THE NATURE AND EXTENT OF THE CHILD'S PRESENTING CONDITION.

1. STUDENT INFORMATION (completed by the school nurse or school homebound coordinator)

Student's Name _____ School Name _____
Date _____ Date of Birth _____
Completed by _____
Grade _____ Parent or Guardian _____
Home Phone Number _____ Cell Number _____
Work Number _____
Home Address _____ Home E-mail _____

2. PHYSICIAN INFORMATION (completed by a physician licensed to practice medicine in all of its branches, a licensed physician assistant, or a licensed advanced practice registered nurse)

Physician's Name (Print) _____ Physician's License Number _____
Physician's Specialty (area of practice) _____
Phone _____ Fax _____ Physician's E-mail _____
Hospital(s) Affiliation(s) _____
Physician's Signature _____ Date Signed _____

3. STUDENT ELIGIBILITY (completed by a physician licensed to practice medicine in all of its branches, a licensed physician assistant, or a licensed advanced practice registered nurse - please attach physician's orders)

Medical Diagnosis _____

Medication(s) _____

Date of Most Recent Medical Examination _____

Specify Ongoing Treatment and Interventions for Medical Condition(s) that preclude the student's attendance in school on a regular basis: _____

Anticipated Return to School Date _____

What is the student's physical and mental tolerance for receiving educational services at least five hours per week? _____

4. OTHER INFORMATION

5. RELEASE OF INFORMATION

I hereby grant my consent to Meridian Community Unit School District No. 223 to communicate and exchange any and all student record and medical information with the medical provider listed above in Section 2 of this form. The purpose for this disclosure is educational planning. If I do not grant this consent, the District will not exchange information with the medical provider, but I will not suffer any other consequences. I understand I have the right to inspect, copy, and challenge the information to be disclosed pursuant to this consent, as well as limit any consent to the designated records or designated portions of the information contained therein. This consent is valid for one calendar year from the date set forth below and may be revoked at any time in writing.

6. SCHOOL NURSE/ADMINISTRATOR INFORMATION (completed by District)

I _____ (print name) contacted the student's physician on _____ (specify the date). In addition, I reviewed all sections of the Medical Referral Form, including letter from the physician and consider the information to be complete and correct.

School Nurse/Administrator signature _____

Date physician contacted/interviewed _____

Date reviewed by school nurse _____

PARENT SIGNATURE

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____