Application for Full-Time Hospital/Homebound Services

MEDICAL CERTIFICATION: Per Illinois School Code, (14-13.01(a)) Homebound services are considered when a licensed physician determines that a student will, due to a medical condition, be out of school for a minimum of two consecutive weeks (10 school days).

Name of Student: _____ D.O.B. _____

Name of School: _____ Grade _____

Part 1: To be completed by Physician licensed to practice medicine in all its branches (M.D. or D.O):

Diagnosis: Please Fill in the following

1. Disease/injury/surgery/other medical condition preventing this student from attending school?

_____

_____

_____

2. If disease, is the disease communicable? ☐ Yes ☐No If yes, please provide instruction to school staff.

_____

_____

_____

3. Nature and extent of medical condition

_____

_____

_____

4. Impact of the medical condition on the child's ability to participate in education (including the child's physical and mental tolerance for receiving educational services)?

_____

_____

_____

5. Date of examination or diagnosis of this illness? _____

6. Is the student confined at home or to a health care facility? ☐ Yes ☐No

7. Could the student attend school if accommodations were made? ☐ Yes ☐No

   If yes, please list the accommodations required. If no, please explain.

_____

_____

_____

8. Estimated date of return to school: _____

9. Ongoing treatment or therapy being provided : _____

_____

_____

10. Frequency of treatment: _____

_____

I certify that this student is unable to attend public school and is medically eligible and physically able to be enrolled in the following program:

Check one (only one): ☐ Hospital Instruction ☐ Homebound Instruction

_____ _____

Name of Physician (printed) Phone

_____ _____

Physician Signature Date

Part 2: To be completed by Parent:

My signature below indicates that I understand that PCCSD 202 Hospital/Homebound Services are designed to provide educational services when a significant medical concern precludes school attendance for a temporary period of time during the school year. Homebound tutoring is designed to provide continuity of educational services between school and home or medical facility and is not designed to replace the educational benefits received during full-time attendance at school. I understand the purpose and limitations of homebound tutoring services. I am applying for homebound services based on the certification of a physician. I understand that homebound services will not begin until this medical certification form is completed and signed by the physician and in the school's possession. I have read the homebound manual and I am aware of the parent/guardian and student responsibilities.

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Signature Date

*Parents/Guardians: Please return this form to your child's school district promptly as services cannot be started until medical information is received. Upon receipt of medical certification, the school district will provide home/hospital services for an eligible student.

SCHOOL DISTRICT USE ONLY:

Date home or hospital instruction began: