CHESTER COUNTY SCHOOLS PHYSICIAN REQUEST FOR HOMEBOUND SERVICES

Completed Form Should be Faxed to (731) 989-4755

This form is required to be completed by a physician when a student is applying for homebound services due to an illness or injury which prevents student's attendance for a duration of **at least ten (10) consecutive school days**. Homebound placements shall not exceed thirty (30) school days duration. **Medical problems which require homebound placement for more than thirty (30) school days will require recertification by a physician.**

PARENT/LEGAL GUARDIAN TO COMPLETE THIS PORTION (Please print)

Student Name____DOB:________________________ Age_______

School ________________________________Grade_____ SPED Services (has an IEP) ☐ yes ☐no Has a 504 plan ☐ yes ☐no

Parent(s)/Guardian(s) ____Best Phone Number_________________________

Physical Address____

Parent/Guardian Email(s)____

Is high speed internet available at home? ___________ Does student have access to a computer/Chromebook at home?_________

Homebound services are requested for the student named above. I grant permission for school officials to contact student's physician regarding this case, and I grant permission for the physician to discuss this case and provide necessary information for school officials. Parent's Signature____ Date ________________

MEDICAL REPORT TO BE COMPLETED BY PHYSICIAN (please print)

The primary method of instruction will be from teacher(s) via electronic delivery. To determine whether it would be in this student's best interest to receive Homebound Services, we require the information below.

Student's Diagnosis: ____

Details of condition that keep student from attending regular classes:____

Medical Treatment/Medications:____

Is student currently immunocompromised ? ☐ Yes ☐ No Please explain:____

Date(s) of hospitalization(s) for this condition: _____________________and/or anticipated date of discharge: ______________

Is Condition Communicable? ☐ Yes ☐ No Is attendance in school safe for student? ☐ Yes ☐ No

Does student have any physical activity restrictions? ☐ Yes ☐ No ____

Is this student physically able to attend regular school? ☐ Yes ☐ No

Is this student physically able to receive home instruction? ☐ Yes ☐ No

Reminder: Homebound placement shall not exceed thirty (30) school days. More than (30) thirty school days will require recertification.

If pregnancy, anticipated due date? _______________________ or actual date of delivery______________________________

Other Information Helpful for Consideration:____

Suggested Date for Homebound to Begin__________________ Dated Student Expected to Return to School ________________

Date of most recent examination________________________Physician's Name____

Field of practice: ☐ Family Practice ☐ Pediatrics ☐ Neurology ☐ Psychiatry ☐ Psychology ☐ Surgery ☐ Other ______________

Name/Mailing Address of Practice : ____

Office Fax Number ______________________________ or Email ____

Physician Signature: ____ Date: __________________________________

Chester County Schools

Request for Medical Narrative Regarding Student Absence

To be completed by school:
Student Name:
Date(s) Absent:

To be completed by physician supervising the medical care:

In Tennessee, we believe student attendance is critical to academic success. When students attend school; they have the opportunity to learn. Students in Tennessee are considered chronically absent when they miss more than 10% of the instructional days for any reason.

Chester County is requesting this statement because the student has already missed seven **(7) or more days or is requesting homebound services** due to medical concerns this academic year.

Please note that if the student has a condition that requires long-term consecutive absences, or only allows for sporadic attendance over a long period of time, homebound services are available through the district.

The signature on this document attests that due to the physical or mental condition of this student, it is/was deemed necessary for the student to miss the entire day or days of school listed above. It is requested that the professional providing the care for the student please sign the document. We appreciate your time in giving this record the attention needed for us to accurately track school attendance.

Date:____

Medical Professional:____

Medical Facility:____

Please attach supporting documentation/narrative.*

Attestation to this narrative could be requested in Juvenile Court to support student claims.