Request for H	Request for Homebound/Hospital Instructions
I. Identifying Information	
Name:	Date of Birth:
School:	School District:
Parent/Guardian:	Phone Number:
Parent email:	
II. Medical Information (check all that apply)	
☐ This student is currently hospitalized; anticipated date of discharge	late of discharge
This student is receiving treatment for a psychiatric i	lent is receiving treatment for a psychiatric illness. (Please include detailed treatment plan.)
Date of most recent evaluation:	Date of re-evaluation:
☐ This student is scheduled or recently received surgery that requires recovery at home.  Surgery:	ry that requires recovery at home. Date:
☐ This student was recently diagnosed with a medical condition that restricts him/her from attending school. Diagnosis:	condition that restricts him/her from attending school.  Date of Onset:
Treatment plan:  □ This student has a chronic illness that will cause intermittent absences.  Diagnosis:  Date of last exam:	Duration of treatment: ermittent absences. st exam:
Treatment required:	

## Marion County Schools Request for Homebound/Hospital Instructions

	Date:					Physician signature:
	Fax:	Į.	***************************************			Address:
	Phone:	P			olease print):	Physician's Name: (please print):
I impact their tion to determine	This documentation is shared in order to inform school personnel of how this student's illness or impairment will impact their ability to attend school and the information may be considered in determining whether to proceed with an evaluation to determine appropriate accommodations to ensure the student's success. Re-evaluation should be completed every 30 days.	inel of how this in determining Re-evaluation s	school persor be considered ent's success.	er to inform mation may ure the stude	is shared in ord ool and the infor oodations to ensi	This documentation is shared in order to inform school personnel of how this student's illn ability to attend school and the information may be considered in determining whether to pappropriate accommodations to ensure the student's success. Re-evaluation should be com
						Comments:
			lation	ınction/ambul	$\square$ Gross motor skills: physical function/ambulation	□Gross motor
	ipulate materials	$\square$ Fine motor skills: ability move/manipulate materials	ne motor skills:		□Weakened immune system	□Weakened ii
	□Risk to self/others	□Strength	□Attention	on abilities	□Communication abilities	□Alertness
; all that apply)	IV. Medical illness and/or treatment may adversely affect the student or cause effects in the following areas: (check all that apply)	udent or cause	ly affect the st	may adverse	md/or treatment	V. Medical illness a
	ule)	or modified schec	hool on ol year. le (abbreviated o	ed return to so shout the scho demic schedul	Extended absence, anticipated return to school on Intermittent absences throughout the school year.  Inability to attend a full academic schedule (abbreviated or modified schedule)	☐ Extended a ☐ Intermitten ☐ Inability to
			: all that apply	ue to: (check	ices requested d	III. Homebound Services requested due to: (check all that apply)