Marion County Schools
Request for Homebound/Hospital Instructions

I. Identifying Information

Name: ______________________ Date of Birth: ____________ ☐ M ☐ F

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 ____________.

☐ This student 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: ______________________ Date: ____________

☐ This student was recently diagnosed with a medical condition that restricts him/her from attending school.
Diagnosis: ______________________ Date of Onset: ________

Treatment plan: Duration of treatment:
☐ This student has a chronic illness that will cause intermittent absences.
Diagnosis: ______________________ Date of last exam: ________ Date of next exam: ________
Treatment required:

III. Homebound Services requested due to: *(check all that apply)*

- ☐ Extended absence, anticipated return to school on ______________________________.
- ☐ Intermittent absences throughout the school year.
- ☐ Inability to attend a full academic schedule (abbreviated or modified schedule)

IV. Medical illness and/or treatment may adversely affect the student or cause effects in the following areas: *(check all that apply)*

☐Alertness ☐Communication abilities ☐Attention ☐Strength ☐Risk to self/others

☐Weakened immune system ☐Fine motor skills: ability move/manipulate materials

☐Gross motor skills: physical function/ambulation

Comments:

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.

Physician's Name: (please print): ______________________________ Phone: ______________________

Address: ____ Fax: ______________________

Physician signature: ______________________________________Date: ______________________