ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Referral for Adjustment of Educational Program

rev. 6.2021

Some students need adjustments to their educational school program due to medical, physical or psychiatric conditions. In these unique instances, instruction may be provided in the home, hospital or treatment center setting. Please complete this form for your student/patient who may meet these distinctive conditions. General education students will receive one (1) hour of education services in the home or hospital setting. Students with an active IEP will receive no less than one (1) hour of education services in the home or hospital setting.

Section 1 is to be completed by the **parent**, **nurse or homebound coordinator** at the attendance school.

Sections 2, 3 and 4 are to be completed by the **Physician. These sections may be completed by a physician licensed to practice medicine in all of its branches, licensed physician's assistant or licensed advanced practice nurse.**

Section 5 is to be completed by the **School Nurse**.

AN UPDATED MEDICAL REFERRAL WILL BE REQUIRED EVERY ONE TO THREE MONTHS DEPENDING ON THE NATURE AND EXTENT OF THE CHILD'S PRESENTING CONDITION. ALL SECTIONS MUST BE COMPLETED BEFORE THE FORM WILL BE REVIEWED AND CONSIDERED.

Send the **Medical Referral, Teacher Application,** and **Teacher Acknowledgment** to the Home and Hospital Instruction Program via the Google form.

1. STUDENT INFORMATION (completed by the School Nurse or School Homebound Coordinator)

Student's Name_____ **School Name**_____

Today's Date_____ **Date of Birth**_____

Completed by_____ **CPS ID#**_____

Grade_____ __**Parent or Guardian**_____

Home Phone Number_____**Cell Number**_____**Work Phone Number**_____

Home Address_____**Home Email Address**_____

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

Physician's Complete Name (Print) _____**Physician's NPI** _____

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 the physician licensed to practice medicine in all of its branches, licensed physician's assistant or licensed advanced practice nurse)

Date of most recent medical examination _____

Diagnosis affecting school attendance_____

Pertinent information which includes <u>how</u> the student's medical/psychiatric condition affects the student's ability to attend school

_____

_____

Referral for Adjustment of Educational Program

rev. 6.2021

Specify ongoing treatment and/interventions for condition that precludes the student's attendance in school _____

Specify all recommended limitations that would prevent student from receiving daily instruction

_____

_____

Medications_____

Pregnant and Parenting Students:

☐ **Pregnancy-Related Condition(s)**- Students who are pregnant are not eligible for homebound instruction unless there are complications associated with the pregnancy, such as toxemia or miscarriage.

Anticipated Delivery Date_____ **Actual Delivery Date**_____

Complications Associated with Pregnancy/Delivery? (Please Check One Box) ☐ **Yes** ☐ **No**

If yes, specify the complications _____

Health of the Baby_____

☐ **Postpartum/Aftercare-**Typically, students return to school after six (6) weeks of homebound instruction unless there were delivery complications, such as a Cesarean section.

4. TEACHING INSTRUCTIONAL DELIVERY SITE (COMPLETED BY THE PHYSICIAN). SELECT THE APPROPRIATE TEACHING SITE FOR THE STUDENT. INDICATE THE ANTICIPATED DURATION OF THE STUDENT'S ABSENCE. HOMEBOUND IS TEMPORARY SUPPORT AND CANNOT BE USED TO REPLACE DAILY CLASSROOM INSTRUCTION OR AS HOMESCHOOL.

☐ Hospital Teaching

Facility _____
Name_____
Student is hospitalized for an acute or chronic medical condition

Start Date_____
End Date_____

☐ Treatment Center Teaching

Facility _____
Name_____
Student has been placed by the district or a court system

Start Date_____
End Date_____

□ Homebound Teaching

Student is anticipated to be to be absent

Start Date_____
End Date_____

☐ Intermittent Home Teaching

Student is chronically ill and may be absent periodically throughout the year

Start Date_____
End Date_____

5. SCHOOL NURSE INFORMATION (completed by School Nurse)

I_____ **(print name of the school nurse) reviewed all sections of the referral form and consider the information to be complete and correct.**

I_____ **(check one)** ☐ **Agree** ☐ **Disagree with the need for homebound instruction.**

Date reviewed by School Nurse_____

School Nurse's signature_____