Campbell County Public Schools
**Cornerstone Learning Center**

194 Dennis Riddle Drive
Rustburg, VA 24588
434-821-6213 ext.8091
Fax 434-821-4512

# HOMEBOUND INSTRUCTION MEDICAL CERTIFICATION OF NEED

Students may receive instruction in the home, a health care facility, or any other approved facility as agreed upon by the school division and parent or student who has reached the age of majority (eligible student).

***If it is necessary for homebound instruction to continue beyond nine weeks, an extension or re-authorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.***

**To be completed by the parent/guardian or eligible student.**

Student: _____DOB: _____ Age: _____ Grade: _____

Name of Parent/Guardian: _____

Telephone: (home) _____(work)_____(cell)_____

Physical Address: _____

Mailing Address: _____

**Acknowledgement/Release:** I acknowledge this request and agree with the need for homebound services. I further acknowledge that the requested homebound services for students receiving special education services shall be subject to review by the student's IEP team pursuant to the Individuals with Disabilities Education Act. ***I will provide an environment conducive to learning, ensure that a responsible adult is in the home for the duration of instruction, or provide transportation to another agreed upon facility. I will keep appointments with the homebound teacher or contact the teacher or homebound coordinator if an appointment must be missed.*** I understand that the local school division has established policies and procedures for homebound instruction that provide more detail than this certificate of need.

**By my signature, I authorize the release and exchange of medical information between the health care provider, listed on the reverse side, or his/her designee, and school division personnel. My signature provides the heath care provider(s) with the authorization necessary to disclose protected health information and records regarding said student as it pertains to the condition for which homebound instructional services are being requested.**

**This authorization may be withdrawn at anytime in writing. Please note: This form, including parental permission to contact the treating physician or psychologist, must be fully completed in order for the student to be considered for homebound services. If you have questions about completing this form, please contact: Jennifer McCormick, Coordinator of Homebound Instruction for Campbell County Public Schools at 434-821-6213 ext 8091.**

_____ _____

**Signature of Parent/Guardian or Eligible Student** **Date**

## HOMEBOUND INSTRUCTION MEDICAL CERTIFICATION OF NEED

Homebound instruction shall be made available to students who are confined at home or in a health care facility for periods that would prevent normal school attendance (8VAC20-131-190). The term "***confined at home or in a health care facility"*** means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment. Students receiving homebound instruction may not work or participate in extra-curricular activities, non-academic activities (such as field trips), or community activities unless these activities are specifically outlined in the students medical plan of care or the Individualized Education Plan (if applicable). Homebound instruction is designed to provide continuity of educational services between the classroom and the home setting or health care facility for students whose medical needs, both physical and psychological, contraindicate school attendance for a **limited period** of time. Homebound instruction is not intended to replace the regular school curriculum, and is therefore, not a guarantee that the student will progress in the academic program.

**To be completed by the licensed physician or licensed clinical psychologist* providing care to the student for the condition for which services are requested.**

1. Name of Student: _____ DOB: _____

2. Name of School: _____ Grade:_____

3. Nature and extent of illness: _____

_____

_____

4. Date of examination or diagnosis of this illness: _____

5. Is the student confined at home or in a health care facility? ❑ YES ❑ NO

6. Is the illness/treatment intermittent in nature (e.g., sickle cell anemia, chemotherapy for childhood cancer)? ❑ YES ❑ NO

7. Could this child attend school if accommodations are made by the school? ❑ YES ❑ NO
If yes, please list the accommodations required. If no, please explain _____

_____

_____

8. Estimated date of return to school (not to exceed 9 weeks) _____

9. Explain ongoing treatment and/or therapy being provided:_____

_____

_____

10. Frequency of treatment: _____

_____ _____
**Signature of Licensed Physician/Clinical Psychologist** **Date**

_____ _____
**Print Physician/Psychologist Name** **Telephone Number**

_____
**Office Address City, State and Zip Code**

* The *Code of Virginia* § 54.1-2957.02 states "whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a nurse practitioner." Revised 2/2012