Student Name:___________________________

HOSPITAL /HOMEBOUND APPLICATION PACKET

Purpose of Homebound Instruction

The purpose of hospital/homebound services in Grant Parish is to temporarily meet the needs of a student who is unable to attend school due to physical or emotional/mental problems. The goal of the program is to assist the student in maintaining his/her educational level and allow a smooth and timely return to the school setting. Hospital/Homebound instruction is not the best educational setting for a student. It is very demanding upon the student, and it is difficult for the student to keep up with missed class work.

Criteria for Acceptance:

1. The original application packet must be completed in its entirety including answers to all questions required of the referring physician, psychiatrist, or certified psychologist and returned to Sharil May at Grant Parish School Board Office by mail or by person. Faxed forms or copies will not be accepted. An original signature (not a stamp) is required of the referring party.
2. The student may not be employed while receiving hospital/homebound services nor may he/she attend after school functions such as dances, ballgames, club meetings, etc.
3. A student must not be recommended for expulsion and/or have an expulsion hearing pending unless determined by the parish superintendent of schools or a hearing officer.
4. A physical referral must be completed by a physician if the student is unable to attend school due to a physical illness or injury. The referring party, a school nurse, the school psychologist, and the SBLC committee will confer as needed regarding the student's condition. These people will make a decision regarding the student's need for homebound services.
5. An emotional/mental referral must be completed by a psychiatrist or licensed psychologist if the student is unable to attend school due to emotional/mental issues. The referring party, a school nurse, the school psychologist, and the SBLC committee will confer as needed regarding the student's condition. These people will make a decision regarding the student's need for homebound services. A student referred for mental/emotional reasons must be actively involved in a treatment program during homebound services. Failure to participate in a treatment program on a regular basis will result in denial of homebound services.

Student Name:___________________________

Please note:

1. If a student has been recommended for expulsion and/or has expulsion hearing pending, homebound services will not be considered until the superintendent has acted upon the recommendations of the expulsion committee.

2. If a student has excessive absences (not due to his/her homebound placement) which prevent a credit in a course, no credit for the course will be given. The homebound student will be instructed only in the areas where he/she is receiving high school credits.

3. An emotional/mental referral by a physician will not be accepted.

4. Pregnancy is not grounds for homebound services. If the student is pregnant, a medical evaluation must verify that there are complications in the pregnancy which could be detrimental to the student to be considered to qualify for services prior to delivery. Students are considered for homebound services 4-6 weeks after delivery. C-section patients are eligible for services up to 6 weeks after delivery.

5. If the student is accepted he/she will be eligible starting on the day the completed application is received by Ms. May at Grant Parish School Board Office. Incomplete forms will delay the process.

6. Once the application is processed, services will begin within 3 days. A homebound teacher will contact the parent/guardian by telephone.

7. The parent should check with the school for assignments until notified that the student has been accepted for homebound services.

8. All textbooks and material are to be picked up at the school by the parent/guardian prior to the first session.

9. A responsible adult, age 21 or older, must be present in the household during homebound sessions. The homebound teacher will not remain in the home if uncomfortable with the adult left in charge. It is best if the person is a parent or guardian.

10. This application will not be processed if the packet is missing required information.

I have read, understood, and accepted the guidelines of Grant Parish School System Hospital/Homebound services.

___________________________________ ___________________________

Signature Parent/Guardian Date

Student Name:___________________________

Information:

Student's Full Name:___________________________________

School: ____________ Grade: ____________ Date of Birth _____________________

Phone #:___________________________ Physical Address:______________________

Mailing Address:____

City:____ Zip Code: _________________

Directions to Home:

____

____

____

____

Does the student have a current Special Education Evaluation?______ Individualized Education Plan (IEP)?________ Behavior Management Plan (BMP)?____________ Individualized Hospital Plan (IHP)?_______________

Student Name:____________________________

CONSENT TO RELEASE MEDICAL INFORMATION

Wavier of Confidentiality Form

All information that has been gathered on an individual is personal and private, and you are not required to release this information. Such information cannot be released without authorized written permission except as required by law.

I UNDERSTAND THAT THE INFORMATION OF:

Name of Student:	Date of Birth:	
Address:	Phone:	
City:	State:	Zip:

IS PERSONAL AND PRIVATE. HOWEVER, I GIVE PERMISSION FOR:

Name of Doctor:		
Address:	Phone:	
City:	State:	Zip:

TO RELEASE TO:

Name: School Nurse, School Level Principal or his/her designee and Sharil May, Supervisor of Special Education Grant Parish School System		
Address: P.O. Box 208		
City: Colfax	State: LA	Zip: 71417

THE FOLLOWING INFORMATION

MEDICAL RECORDS

Student Name:____________________________

I UNDERSTAND THAT I HAVE A RIGHT TO DISCLOSE MY TESTS RESULTS.
(   ) I DO NOT AUTHORIZE THE RELEASE OF MY TEST RESULTS.

THE MEDICAL RECORD OF THE PERSON LISTED ABOVE IS TO BE RELEASED FOR THE SPECIFIC PURPOSE OF:

Comments or Other Information:

I UNDERSTAND THAT MY PERMISSION TO RELEASE TIDS INFORMATION MAY BE CANCELLED ANY TIME EXCEPT WHEN THE INFORMATION HAS ALREADY BEEN RELEASED. MY PERMISSION TO RELEASE THE INFORMATION WILL EXPIRE UPON WRITTEN NOTIFICATION TO THE SCHOOL NURSE AND SHARIL MAY AT THE ABOVE ADDRESS.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PARENT/GUARDIAN OF THE PERSON LISTED ABOVE AND HAS THE LEGAL AUTHORIZATION TO SIGN ON BEHALF OF THE PERSON WHETHER BY COURT ORDER OR OPERATION OF LAW.

Signature of Parent/Guardian:
Date:

Student Name:___________________________

HOSPITAL/HOMEBOUND REFERRAL FOR TEMPORARY PLACEMENT DUE TO PHYSICAL ILLNESS

Doctors, Please Note:

1. Homebound services are temporary services to be requested only when a student absolutely cannot attend school.
2. Expectant mothers may be served 4 weeks prior to delivery and 4-6 after delivery (6 weeks is for C-Section deliveries.)
3. It is very difficult for a student to keep up with schoolwork while receiving homebound services.
4. Registered nurses monitor student needs and medications at each school.

Student:____________________Age:______ Date of Birth:__________ Gender:________

Parent/Guardian__________________Home Phone #____________(work)___________

Address:_________________________City:___________________Zip Code:_________

Medical Certification:
This referral must be completed by a physician if the student is unable to attend school due to a physical injury or illness. All questions must be answered for the application to be processed.

1. Is the student's condition to a degree he/she cannot attend school at all?______________
2. What is the specific diagnosis of the patient's condition which prevents his/her school attendance?
   ____
3. What specific treatment and/or medication is the patient currently receiving to improve this condition?
   ____
4. What specific limitations of the patient are preventing school attendance?
   ____
5. If this is a pregnancy referral, what is the expected delivery date of the patient?_______
6. For all patients, what is the requested duration of homebound services for this patient?

   _____3 weeks _____4 weeks _____6 weeks _____8 weeks (maximum time without further referral from a physician). It is required that the patient and the physician and have a new referral completed if the student cannot return to school after the initial requested time.

Hospital/Homebound Beginning Date________________Ending Date__________________

Physician's Name (Please Print)____

Address:_____________________________________Phone:__________Fax: __________

City:_________________________State:___________________Zip Code:____________

Physician's Original Signature__________________________Date of Referral__________
(Stamped signature will not be accepted)

** Please return to: Grant Parish School Board, Attention Sharil May/Homebound Services, PO Box 208, Colfax, LA 71417

Student Name:_______________________________

HOSPITAL/HOMEBOUND REFERRAL FOR TEMPORARY PLACEMENT DUE TO EMOTIONAL/MENTAL ILLNESS

Psychiatrist/Licensed Psychologists, Please Note:

1. Homebound services are temporary services to be requested only when a student absolutely cannot attend school.

2. It is very difficult for a student to keep up with schoolwork while receiving homebound services.

3. Registered nurses monitor student needs and medications at each school.

Student:______________________________Age:_________Date of Birth:____________Gender:_____

Parent/Guardian___________________________________Home Phone #__________(work)_________

Address:_________________________________City:_____________________Zip Code____________

Mental/Emotional Certification:

This referral must be completed by a psychiatrist or licensed psychologist if the student is unable to attend school due to a mental illness, emotional crisis or the treatment thereof. All questions must be answered for the application to be processed.

1. Is the student seriously emotionally disturbed to a degree he/she cannot attend school at all?
2. What is the specific diagnosis of the patient's condition which prevents his/her attendance at school?
3. Is the patent receiving regular counseling? If not, the student is ineligible for homebound services. If so, how often is the patent seen for counseling?________What is the expected duration of this counseling?_____________________________
4. What medication is the patent currently receiving?____
5. What is the requested duration of homebound educational services?

   ______3 weeks______4 weeks______6 weeks______8 weeks (maximum time without further referral from a licensed psychologist). It is required that the patient re-visit the psychiatrist or licensed psychologist and have a new referral completed if the student cannot return to school after the initial requested time.

Hospital/Homebound Beginning Date_______________Ending Date_____________

Psychiatrist or Licensed Psychologist's Name (Please Print)_________________________________

Address:______________________________________Phone:______________Fax:_____________

City:______________________________State:_____________________Zip Code:_____________

Psychiatrist or Licensed Psychologist’s Original Signature __________________________________
(Stamped signature will not be accepted)
Date of Referral:______________________

** Please return from to: Grant Parish School Board, Attention Sharil May/Homebound Services, PO Box 208, Colfax, LA 71417

Updated: September 9, 2015