2024-2025 ESCUELAS DEL CONDADO DE WARREN DOCUMENTACIÓN DEL PROVEEDOR DE ATENCIÓN MÉDICA DEL PROGRAMA DE CLASES A DOMICILIO

Este formulario es requerido cuando los estudiantes solicitan los servicios de clases a domicilio debido a enfermedad, accidente o embarazo que impide la asistencia a la escuela durante por lo menos dos semanas o más. Cuando las complicaciones de las condiciones médicas requieren la colocación en clases domiciliarias que exceden de la certificación inicial, un formulario de recertificación debe ser completado y firmado por el MÉDICO TRATANTE. Por favor comuníquese con Jeffery Martin at (931)668-4022 or Sonja Walker, RN (931)668-4022 con cualquier pregunta relacionada con los servicios de clases a domicilio. Gracias

PARA SER COMPLETADA POR LOS PADRES: (Por favor, con letra molde)

Nombre del Estudiante _____ Fecha de Nacimiento _____

Escuela_____ Grado _____ Género_____

Padre(s) _____

Domicilio_____

Núm. de Teléfono (casa)_____(trabajo)_____(celular) _____

TO BE COMPLETED BY PHYSICIAN: (Please Print)

Physician _____ Phone _____ Fax_____

Address _____ City, State, Zip _____

Date Last Examined _____ Diagnosis/Etiology_____

***** Students requesting Homebound for Pregnancy please complete info in box below *****

Prognosis _____Communicable Status _____ Immunocompromised Status_____

Treatment Plan_____

_____

Medication(s) _____

Restrictions of physical activity ( ) yes ( ) no. If yes, specify nature and duration of restriction _____

_____

DATE HOMEBOUND TO BEGIN_____ DATE EXPECTED TO RETURN TO SCHOOL _____

HOMEBOUND PLACEMENTS SHALL NOT EXCEED THIRTY (30) SCHOOL DAYS DURATION *(days that school is in session). If student needs extra time, a recertification form must be completed & turned in prior to end of initial certification.*

*****TO BE COMPLETED FOR PREGNANCY ONLY*****

_____ Expected Date of Delivery

Is the student medically unable to attend class because of health complications arising from the pregnancy?
_____YES - List complication(s):_____

******Complications should be of a nature as to have a diagnosis code. Some examples are gestational diabetes, pre-term labor (PTL), eclampsia, toxemia, pregnancy induced hypertension (PIH), etc. & must be supported by documentation from office visits and/or hospitalization admission and discharge summary.***

____ NO- Normal pregnancy ____ *Date of Delivery* _____

ALL HOMEBOUND PLACEMENTS SHALL BE TEMPORARY. HOMEBOUND PLACEMENTS SHALL NOT EXCEED THIRTY (30) SCHOOL DAYS DURATION. WHEN COMPLICATIONS FROM A MEDICAL CONDITION REQUIRE HOMEBOUND PLACEMENT TO EXCEED THE INITIAL CERTIFICATION, A RECERTIFICATION FORM MUST BE COMPLETED AND TURNED IN TO THE CENTRAL OFFICE PRIOR TO THE END OF THE INITIAL CERTIFICATION PERIOD.

Signature of Treating Physician _____ Date_____

FORM MUST BE SIGNED BY TREATING Physician WHICH MAY INCLUDE SURGEONS, OSTEOPATHIC PHYSICIANS, NURSE PRACTITIONERS, LICENSED PSYCHOLOGIST & LCSW *(A PERSON WHO IS LICENSED UNDER T.C.A. TITLE 63, CHAPTER 6; T.C.A. TITLE 63, CHAPTER 9; T.C.A. TITLE 63, CHAPTER 11; OR T.C.A. § 63-23-105 OR SIMILAR STATUTE IN ANOTHER JURISDICTION AND WHO IS THE PROFESSIONAL TREATING THE STUDENT FOR THE MEDICAL CONDITION REQUIRING HOMEBOUND INSTRUCTION. T.C.A.§§ 0520-01-02-.10)*

REVISED: MAY 24, 2024