2017-2018 WARREN COUNTY SCHOOLS HOMEBOUND PROGRAM
HEALTHCARE PROVIDER DOCUMENTATION

This form is required when students are applying for homebound services due to an illness, injury, or pregnancy that prevents school attendance for duration of at least two weeks or more. When complications from a medical condition require homebound placement past the initial certification, a recertification form must be completed. Please contact Jeffery Martin at (931)668-4022 ext. 230 or Sonja Walker, RN (931)668-4022 ext. 267 with any questions regarding homebound services. Thank you

TO BE COMPLETED BY PARENT: (Please Print)

Student Name _____ Date of Birth _____

School_____ Grade _____ Gender_____

Parent(s) _____

Address_____

Phone Number (home)_____(work)_____(cell)_____

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: _____

*****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. Abdominal pain, back pain, nausea, & fatigue are common to pregnancy & are not considered complications for the purpose of homebound instruction.***

____ **NO- Normal pregnancy**

____ **6-week post-partum care: *Date of Delivery*** _____

____ **Beyond six weeks post-partum – list medical complications of student**:_____

_____

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 (MORE THAN 30 SCHOOL DAYS) A RECERTIFICATION FORM MUST BE COMPLETED.

Signature of Physician _____ Date_____

FORM MUST BE SIGNED BY PRIMARY OR TREATING LICENSED PHYSICIAN ONLY

NO NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR STAMPED SIGNATURE ACCEPTED

Revised 5/25/17