2026-2027 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 and signed by the TREATING PHYSICIAN. Please contact Jeffery Martin at (931)668-4022 or Sonja Walker, RN (931)668-4022 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_____

Parent's Email: _____

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 _____

HOMEBOUND PLACEMENTS SHALL NOT EXCEED THIRTY (30) SCHOOL DAYS DURATION *(days that school is in session). If a student needs extra time, a recertification form must be completed & turned in prior to the 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.§§ 49-10-1101)*

REVISED: MAY 22, 2026