The School District of Osceola County
Office of Exceptional Student Education
Hospital/Homebound (H/H) Request

SECTION I: STUDENT INFORMATION
To be completed by parent/legal guardian (please print)

Student ID#	Student First Name	MI	Last Name	Birth Date	ESE Program/504

Grade	Current School	Parent/Legal Guardian Name

Parent/Legal Guardian E-Mail Address	Parent/Legal Guardian Preferred Phone #	Alternate Phone#

Parent/Legal Guardian Address	City	State	Zip Code

Parent/Guardian: Please review the Hospital Homebound program expectations:

- Eligibility is based on Florida Statutes, State Board Rule 6A-6.03020, and that the physician statement is part of the information to determine eligibility. The School District of Osceola County Hospital/Homebound personnel may contact the licensed physician who completed the request to obtain information to determine eligibility.
- It is my responsibility to continue requesting and submitting completed assignments/makeup work, until my student is found eligible and placed on Hospital Homebound as grades will transfer with the student.
- If my child is too ill to attend school, I must continue to report absences to the school, per district policy, until an eligibility meeting and I give official written consent for instruction to be provided through Hospital/Homebound.
- This request does not guarantee placement in the Hospital/Homebound Program.
- State eligibility criteria for Hospital/Homebound services require that the child be **confined** to the home or hospital. The only exception is if part-time placement is being requested.
- The Hospital/Homebound program is designed to be a **temporary** educational program to help students who are unable to attend school for medical or psychiatric reasons, not intended to address non-medical attendance concerns.
- The student may not be employed, participate in extracurricular activities, or go away on vacation.
- The Hospital/Homebound Program cannot duplicate the classroom experience, the amount of academic instruction provided, not all courses provided at a school site (only core-academic courses are provided).
- High school electives are not provided under hospital/homebound and should be completed via another platform.
- The Hospital/Homebound program follows the School District of Osceola County calendar. Services will not occur during student holidays or any days that students would not regularly be in school (weekends/breaks/summer).
- If eligible, students are subject to the same mandatory School District of Osceola County attendance policy.
- The parent/guardian shall provide a safe, quiet, clean, well-ventilated setting where the student can participate in instruction with no distractions.
- A parent/guardian or adult designee must be present during all instructional sessions and sign the teacher's instructional time sheet after each session.

Dismissal from Hospital/Homebound may occur for the following reasons:

- A Florida licensed physician indicates a student can return to the home zone school.
- The student is no longer confined to the hospital or home, known to be working, or goes on vacation.
- The student fails to attend instructional sessions or complete online work as required by academic pacing.
- The Hospital/Homebound Request expires.

I have read and agree to the Hospital/Homebound policies, procedures, and requirements for eligibility and placement, and I understand the reasons for dismissal. I understand my signature below provides consent for evaluation to consider eligibility for Hospital/Homebound services.

_______________________________________ ____________

Signature of Parent/Legal Guardian **Date**

To be completed by school only.

DATE RECEIVED

______/______/______

MM DD YY

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Parent/Guardian Authorization for Release and Exchange of Information

I hereby authorize the student's physician(s) to release all information concerning diagnoses, treatment plan, medical implications or instruction, and reentry plan to the School District of Osceola County. **This communication may be written or verbal.** This release will remain in effect until the student has been dismissed/discontinued from the Hospital/Homebound program.

____ _________________

Parent/Legal Guardian Signature Date

SECTION II: MEDICAL INFORMATION

TO BE COMPLETED BY A FLORIDA LICENSED PHYSICIAN/PSYCHIATRIST
Information must be printed. If completed by a licensed ARNP or P/A, the name of the licensed supervising physician must be noted on the bottom of page 3.

Physician/Psychiatrist Information

Physician Name	Area of Practice	License Number	Licensing State

Address	City	State	Zip Code

Physician E-Mail Address	Physician Phone #	Fax #

Student Medical Information & Certification

The student mentioned above is being considered for Hospital/Homebound instructional services based on a medical or psychiatric diagnosis **confining** the student to the home or hospital. Please complete the information below providing details regarding the medical diagnosis to assist us in making appropriate educational decisions. Please keep in mind, hospital/homebound services are limited and basic in nature. Our goals are to minimize instructional gaps by providing **temporary** access to academic curriculum while the student is medically **confined** and to promote reentry into a traditional school setting.

Date of Onset of Condition	Date Last Seen by Physician
Please indicate the student's diagnosis (no ICD9 codes) that prohibits your patient from attending school.	
Describe your treatment plan for this student (please include any medical/psychiatric appointments, frequency, and duration of the treatments).	
Nature of **Confinement**: Explain in detail how the medical or psychiatric condition you have diagnosed prevents the student from attending the regular school setting (to what degree is the student **confined** to the home/hospital).	

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What are your recommendations for school re-entry and other school-related activities?

Required from Physician: Provide an estimated duration of the condition or prognosis.

Required from Physician: Provide recommended dates for confinement to the home or hospital:

Beginning of Confinement: _ ______/________/____________End of Confinement:__________/________/__________(date of return to school)
Month Day Year Month Day Year

**Please note: a request cannot exceed one calendar year. If this section is left blank, it will delay the process of this request.*

Required from Physician: The student is recommended to be confined to the home or hospital as checked below: (Check only one option)

☐ Intermittent: Student can attend home zone school most school days; student may be ill occasionally.

☐ Partial Day: Student can attend school part of every day during a recuperative period of readjustment to a full day.

If eligible, how many hours should the student be able to attend school? _________

☐ Full-Time: Student is not able to attend school at a school site due to the need for full time confinement.

If eligible, how many hours of hospital/homebound schoolwork should this student be able to endure each day?
Please check one:

☐ 7 hours ☐ 6 hours ☐ 5 hours ☐ 4 hours ☐ 3 hours ☐ 2 hours ☐ 1 hour

☐ None of the Above: Student can attend school full time.

Medical Certification **All questions must be answered by the physician**	**Initial below** to indicate a response of "Yes" or "No"	
	Yes	No
Is the student expected to be absent from school due to the medical condition for at least fifteen (15) consecutive days, or absent due to a chronic medical condition for at least fifteen (15) non-consecutive days.		
Will the student be **confined** to the home or hospital during the time hospital/homebound services are expected?		
Will the student be able to participate in and benefit from an instructional program provided through a hospital/homebound program?		
Is the student under medical care for the illness or injury that is **acute, catastrophic, or chronic in nature?**		
Can the student receive hospital/homebound instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact with?		
Is the student able to go to a school site to take standardized/semester assessments?		

Physician's Signature:_______________________________________Date: _______________________

****Signature Required (Stamp NOT Accepted)**

A "licensed physician" means one who is qualified to assess the student's physical or psychiatric condition (M.D. or D.O.).
An ARNP or PA working for a physician licensed under the authority of sections 458 or 459, F.S., may sign this medical statement instead of the physician. The name of the licensed physician must be noted on the statement in addition to the signature.

Please Print Supervising Physician and Title ___________________________________ Phone Number ________________
Supervising Physician Signature ____