Marion County Schools
Request for Homebound/Hospital Instructions

I. Identifying Information

Name: _____ Date of Birth: _____ ☐ M ☐ F

School: _____ School District: _____

Parent/Guardian: _____ Phone Number: _____

Parent email: _____

II. Medical Information *(check all that apply)*

☐ This student is currently hospitalized; anticipated date of discharge _____.

☐ This student is receiving treatment for a psychiatric illness. *(Please include detailed treatment plan.)*

Date of most recent evaluation: _____ Date of re-evaluation: _____

☐ This student is scheduled or recently received surgery that requires recovery at home.
Surgery: _____ Date: _____

☐ This student was recently diagnosed with a medical condition that restricts him/her from attending school.
Diagnosis: _____ Date of Onset: _____

Treatment plan: Duration of treatment:
☐ This student has a chronic illness that will cause intermittent absences.
Diagnosis: _____ Date of last exam: _____ Date of next exam: _____
Treatment required:

III. Homebound Services requested due to: *(check all that apply)*

☐ Extended absence, anticipated return to school on _____.
☐ Intermittent absences throughout the school year.
☐ Inability to attend a full academic schedule (abbreviated or modified schedule)

IV. Medical illness and/or treatment may adversely affect the student or cause effects in the following areas: *(check all that apply)*

☐Alertness ☐Communication abilities ☐Attention ☐Strength ☐Risk to self/others

☐Weakened immune system ☐Fine motor skills: ability move/manipulate materials

☐Gross motor skills: physical function/ambulation

Comments:

This documentation is shared in order to inform school personnel of how this student's illness or impairment will impact their ability to attend school and the information may be considered in determining whether to proceed with an evaluation to determine appropriate accommodations to ensure the student's success. Re-evaluation should be completed every 30 days.

Physician's Name: (please print): _____ Phone: _____

Address: _____ Fax: _____

Physician signature: _____Date: _____