

Homebound Instruction – Medical Certification of Need: (Part II):

To be completed by a licensed physician or a licensed clinical psychiatrist/psychologist providing care to the student for the condition in which services are requested. If your child has a **mental health** condition a signature is needed from the treating doctor’s office where there is **a licensed psychiatrist or psychologist**. Additional questions about completing this form should be directed to the Homebound Program Teacher Specialist, Madelyn Swing, at 757-628-3950 ext. 21254 or mswing@nps.k12.va.us.

Physicians Name: _____ Specialty: _____

License #: _____

Assisting Nurse/contact person: _____

Email address: _____

Address: _____ suite/bldg. #: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ fax#: (____) _____

Patient Information: Please answer ALL Questions

Student Name: _____ D.O.B. _____

Date of most recent exam: _____ Next Exam/Follow up date: _____

Is this student pregnant? ____ if yes, EDD: _____ Is this a high-risk pregnancy? ____

Is this student **unable** to attend school regularly due to illness, surgery or other **physical medical condition(s)**? YES/ NO

What is the specific nature, and extent of the physical illness or condition? _____

Is this student **unable** to attend school regularly due to a **mental health diagnosis**? Yes No

If yes, what is the mental health diagnoses? _____

Is this illness/treatment Intermittent? Yes No Is this illness/treatment continuous? Yes No

Please specify the treatment plan (attach an additional sheet if necessary): _____

Student Name: _____

Homebound Instruction – Medical Certification of Need (Part II cont.)

Please answer ALL Questions

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Is the parent & student complying with the treatment plan? YES/NO

If **NO**, please explain: _____

Could the student attend school if accommodations are made? YES/NO? If **YES**, what accommodations are needed? _____

If **NO**, please explain _____

Can this student attend school part- time? If yes, maximum # of hours per day: _____

Date Homebound instruction should begin: _____ Estimated date of return: _____

Anything beyond 9 weeks/45 days from the start date will require a Medical Need Extension Request form

Homebound instruction shall be made available to students who are confined at home or in a health care facility for periods that would prevent normal school attendance (8VAC20-131-180). The term “*confined at home or in a health care facility*” means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment.

By signing below, as the licensed doctor, you certify the above statement, applies to the patient on this form:

X _____ License #: _____

(Signature of licensed Physician or licensed psychologist/psychiatrist)

X _____ Date: _____

(Printed name of licensed Physician or licensed psychologist/psychiatrist)