Harrisonburg City Public Schools

One Court Square • Harrisonburg, VA 22801
Phone: 540.434.2752 • Fax: 540.432.3258

Homebound Instruction - Medical Certification of Need & Extension

Student Name: _____ Requires: ☐ Full-time homebound

By signing this form I acknowledge and agree to comply with the following statements:

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 which means the student is (1) unable to participate in the normal day-to-day activities typically expected during school attendance and (2) absences from the home during confinement are infrequent, for periods of relatively short duration, or to receive health care treatment.

Homebound instruction is designed to provide continuity of educational services between the classroom and the home setting or health care facility for students whose medical needs, both physical and psychological, contraindicate school attendance for a **limited period (9 weeks or less)** of time. Homebound instruction is not intended to replace the regular school curriculum, and is therefore not a guarantee that the student will progress in the academic program. Prior to requesting homebound services, the parent/guardian should explore options for school-based instruction with school personnel.

- ❖ Medical or Clinical Diagnosis resulting in a need for homebound services:

_____

- ❖ Date of examination or diagnosis of this illness: _____
- ❖ Please describe the current treatment plan and previous interventions (frequency, duration, outcome). _____

_____

- ❖ Could this child attend school if accommodations are made by the school? ☐ Yes ☐ No

Note: Accommodations that may be provided by HCPS include but are not limited to: shortened day (early release, late arrival), breaks during the instructional day, access to counselor, behavior plan, health plan, self-paced computer assisted instruction.

- ❖ **If yes**, what are the required accommodations:

_____

- ❖ **If no,** what needs to happen in order for a student to return to school (transition recommendations)?

_____

- ❖ Length of time homebound instruction is anticipated **(9 weeks or less)**:

Start Date: _____ **End Date:** _____

Printed Name of Physician/N.P. or LCP: _____ **Phone:** _____

Signature of Physician/N.P. or LCP: _____ **Date:** _____

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COMPLETE ONLY FOR EXTENSION OF HOMEBOUND: Since homebound instruction is not intended to supplant school services and is by design temporary, if it is necessary to extend homebound instruction beyond the initial time frame or longer than 9 calendar weeks, a transition plan with the following data is required.

- Justification for the extension:

- Specific steps planned to return the student to the classroom:

- Explain the **on-going** treatment and/or therapy being provided:

- New Homebound end date: _____

Printed Name of Physician/N.P. or LCP: _____ **Phone** _____

Signature of Physician/N.P. or LCP: _____ **Date:** _____