THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA

PARENT AGREEMENT FOR HOSPITAL/HOMEBOUND SERVICES

Student Name: _____ ID#: _____ School: _____

PRELIMINARY REQUIREMENTS:

1. The student must be enrolled in the Martin County School District.
2. A Florida licensed physician must certify that: (a) due to a medical or psychiatric condition**, confinement to the hospital/home** is necessary for at least 15 consecutive school days (or 8 days block equivalent) during which the student will be able to participate in and benefit from an instructional program, and (b) that the condition will not endanger the teacher's health or the health of others students the teacher serves.
3. If the condition is psychiatric in nature, the student must be actively participating in a regularly-scheduled, physician-developed treatment plan. The Hospital/Homebound office must have received a copy of this physician-developed treatment plan and expected date that student will return to school prior to services being initiated. A completed medical referral will be submitted for all subsequent recommendations.

In order to provide your child with services through the Hospital/Homebound Program, we must have your assurance that you will assist us in the following ways:

1. Providing a clean, quiet, well-ventilated/smoke free setting where the teacher and student can work.
2. Ensuring that a responsible adult (age 18 or older) is present during all sessions.
3. Establishing a study schedule for the student to follow between teacher visits.
4. Notifying the Hospital/Homebound Teacher or office when an instructional visit must be cancelled by calling 219-1200, ext. 30427. (Parents, NOT students, must make this notification.)
5. Reporting with the student to the guidance or registrar's office at the school site upon his/her return to the school site.

Hospital/Homebound Program instruction will be terminated for the following reasons:

1. Failure of parent/student to comply with the Hospital/Homebound Program requirements listed above.
2. Physician's recommendation that the student is able to return to school.
3. The student is working or goes on vacation.
4. The end of the school year.
5. Failure to make adequate progress.

Parent/guardian has been informed that due to the limited nature of hospital homebound instruction and reduced instructional time, students may lag behind their peers and will be responsible for making up any missing assignments upon returning to school. Additionally, some classes may need to be completed through Edgenuity.

I have read and agree to comply with the requirements of the Hospital/Homebound Program.

_____ _____

Parent/Guardian Signature Date

HOSPITAL/HOMEBOUND MEDICAL REFERRAL FORM

TO BE COMPLETED BY PARENT/GUARDIAN

I. Student Information Referral Date:_____

Name:_____ ID #:_____ School:_____

Grade:_____ Birth date:_____ Address:_____

Tele. #s:_____

Treating Physician:_____ Tele. #:_____

Fax #: _____

II. Parent/Guardian Permission to Release Records

I am requesting Hospital/Homebound instruction for the above named student and hereby give permission to the physician/therapist to release medical information on the student's medical/psychiatric condition to Martin County School District Personnel. Name and phone number of physician must be legible.

_____

Parent/Guardian Signature Date

Rule 6A-6.03020, Florida Administrative Code (FAC), identifies a Hospital/Homebound student as a student who has a medically diagnosed physical or psychiatric condition that is acute or catastrophic in nature, or a chronic illness, or a repeated intermittent illness due to a persisting medical/psychiatric problem. The condition must confine the student to the hospital or home and restrict activities for an extended period of time. The eligibility criteria for pregnant students are the same. The physician must indicate the specific medical condition, in addition to pregnancy, that necessitates the request for Hospital/Homebound services; the estimated delivery date; and the estimated length of time the student will be confined. The medical condition necessitating services may be related to the pregnancy. The pregnancy, in and of itself, does not constitute eligibility for Hospital/Homebound services.

RETURN COMPLETED FORM & TREATMENT PLAN TO:
ESE Hospital/Homebound Program
1939 SE Federal Highway. Stuart, FL 34994
TEL. # 772-219-1200, ext. 30427
Fax # 772-219-1228

Section III must be completed by a Florida licensed physician.

III. Medical/Psychiatric Condition

Diagnosis_____

Date of Onset_____ Prognosis: (circle one) Good Stable Guarded

The student is unable to attend school due to being confined to: (circle one) Hospital Home

Hospital/Homebound services are recommended: (circle one) Yes No

The student can receive services without endangering their health, the health of the teacher or other students served by the teacher. (Circle one) Yes No

Date the student will be able to participate in and benefit from Hospital/Homebound services: _____

This medical referral expires on: _____ **(services will be provided as per the current school year calendar)**

NOTE: If recommended for school re-entry prior to expiration of this medical referral, a letter, signed by the treating physician, stating that the student is medically able/released to return to school MUST be received prior to re-entry.

Comments: A copy of the Physician's Treatment Plan MUST be received prior to the initiation of Hospital/Homebound services. *The plan of care must, at minimum, include: schedule of regular visits (weekly, biweekly, monthly, etc.); prescribed medication(s) and implications for instruction; next scheduled office visit; outside activity restrictions; and recommendations for date of re-entry into school.*

_____ _____

Signature Treating Physician Date

Signature of physician must be legible

THE SCHOOL DISTRICT OF MARTIN COUNTY, FLORIDA

Treatment Plan for Hospital/Homebound Students

Note to Physician: Please understand that hospital/homebound is a temporary setting for students who are confined to the hospital or to home and unable to attend a school campus. This will result in decreased instructional time and may cause the student to significantly lag behind their peers in school.

Student Name:_____ Birthdate:_____ School:_____

1. Description of the student's current diagnosis/condition:

2. Schedule of regular visits (weekly, biweekly, monthly, etc.):

3. Next scheduled office visit:

4. Current medication(s) and implications for instruction:

Medication(s)	Instructional Implications

5. Current restrictions that require this student to be confined to home:

6. Describe the goals/objectives for treatment including recommendations and anticipated date for school re-entry. Please state what accommodations this students requires in order to attend a school campus.

_____ _____

Treating Physician's Signature Date