PORTSMOUTH PUBLIC SCHOOLS
SHINING BRIGHTER TOGETHER

Office of Homebound and Home Instruction
Department of Curriculum and Instruction • Student Services
3651 Hartford Street • Portsmouth, Virginia 23707-1205
Phone: 757-393-8354

To: Physician, Hospital, Clinic
From: Dr. Angela Flowers, Coordinator of Student Services

Re: Extension for Regular Homebound

Homebound Instruction is being considered for the student listed below. 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. Students receiving homebound instruction may not work or participate in extra-curricular activities, non-academic activities (such as field trips), or community activities unless these activities are specifically outlined in the students medical plan of care or the Individualized Education Program (if applicable). Incomplete forms will be denied.

The original form completed by the parent and doctor must be returned to the Homebound Office

Section I (Completed by parent)

Name of Student _____School _____ Student Number _____

Grade _____ DOB _____ Gender M___ F___ **IEP** Yes___ No___ **504 Plan** Yes ___ No___

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ Zip Code _____

Parent/Guardian (print) _____ Email Address: _____

Acknowledgement/Release: I acknowledge this request and agree with the need for homebound services. I further acknowledge that the requested homebound services for students receiving special education services shall be subject to review by the student's IEP Team pursuant to the *Individuals with Disabilities Education Act*. I will provide an environment conducive to learning, ensure that a responsible adult is in the home for the duration of instruction, or provide transportation to another agreed upon facility. I will keep appointments with the homebound teacher and contact the teacher/homebound coordinator if an appointment must be missed. I understand that consistent cancellation of services may be grounds for termination and my child must return to in-person school attendance. I understand if homebound services are provided virtually, the sessions will be recorded.

I understand that the local school division has established policies and procedures for homebound instruction that provide more detail than this certificate of need. By my signature, I authorize the release and exchange of medical information between the health care provider, listed on the reverse side, or his/her designee, and school division personnel. My signature provides the heath care provider(s) with the authorization necessary to disclose protected health information and records regarding said student as it pertains to the condition for which homebound instructional services are being requested. This authorization may be withdrawn at any time in writing.
Please note: This form, including parental permission to contact the treating physician or psychologist, must be fully completed in order for the student to be considered for an extension of homebound services.

The Homebound Office has my permission to exchange information with the Physician's Office.

Parent/Guardian Signature Date

*The *Code of Virginia* § 54.1-2957.02 states "whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a nurse practitioner."

Professional advice is necessary in determining whether or not he/she is able to attend school. Re-evaluation is needed for consideration of services being extending. If it is necessary for homebound instruction to continue beyond nine weeks, an extension or reauthorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.

Section II (To be completed by the licensed physician or licensed psychologist providing care to the student for the condition for which homebound is being requested)

1. Medical Condition for homebound request (Describe the Nature of the Illness)

   _____

2. Date of examination or diagnosis of this illness (current within 30 days _____
3. Is the student confined at home or in a healthcare facility? Yes _____ No _____
4. Could the student attend school if accommodations are made by the school? Yes ___ No ___

   If yes, please list the accommodations required _____

   _____

   _____

   _____

   If no, please explain _____

   _____

   _____

5. When do you recommend that homebound instruction begin? ***Specific begin and end dates must be provided (up to 45 days within the school year).*** **Begin Date** ____/__/____ **End Date** ___/__/____
6. Explain ongoing treatment and/or therapy being provided:

   _____

   _____

   _____

7. Recommendations regarding the school related activities to be encouraged or avoided after return to school.

   Encouraged: _____

   Avoided: _____

I certify the above named student is not able to attend school or work due to the medical diagnosis.

PRINT License Physician's Name _____Telephone Number _____

Licensed Physician's Signature _____ Date _____ Fax Number _____

HOMEBOUND OFFICE USE ONLY

Approved __
Denied ___ Coordinator's Signature _____ Date _____