HORRY COUNTY SCHOOLS
Office of Health Services
P.O. BOX 260005
CONWAY, SC 29528
Phone (843) 488-6805 Fax (843) 488-6952

Updated June 2014
HB-1

MEDICAL HOMEBOUND PHYSICIAN AUTHORIZATION FORM

Dear Physician*:*

Thank you for your dedication in keeping students in South Carolina healthy and progressing academically and socially in the regular school environment to the extent that is appropriate. The below named student and his/her parent, legal guardian, or surrogate parent has requested that the school district provide medical homebound instruction due to the student's inability to come to school as a result of an illness or accident even with the aid of transportation. A district representative may contact you to discuss strategies to maintain the student in the school environment and to request additional information. The district superintendent or his/her designee must approve any student participating in a program for medical homebound instruction or hospitalized instruction. **Please complete Section II as indicated. Any medical questions should be addressed to Tammy Trulove, Director of Health and Safety Services at (843) 488-6805.**

SECTION I – STUDENT INFORMATION: (To be completed by school district personnel)

Student's Name:	Date of Birth:	Age:	Grade:
School:	School Year: **2014-2015**	Is this student classified as disabled? Yes____ No____ Area of Disability_____	
Last Date of Pupil Attendance: ____/____/_____ Number of Absences to Date: _____			
Does the student currently have an Attendance Intervention Plan (AIP)? Yes ☐ No ☐ Is the student currently enrolled at HCEC? Yes ☐ No ☐			

SECTION II – MEDICAL INFORMATION: (To be completed by a ***licensed physician***)

Diagnosis or condition that **prevents** school attendance: (Attach additional information if needed)

How does this medical condition impact educational performance? Would this student be able to attend school if accommodations were made? (Attach additional information if needed)

Treatment Plans: (Please include details, i.e.; medication, counseling schedule, etc., concerning your plans for returning the student to school) (Attach additional information if needed) **Per South Carolina department of Education guidelines, if a mental health diagnosis indicates that long-term medical homebound instruction will be necessary, the District will advise the parent to make arrangements with a licensed mental health care professional to develop and submit a treatment plan and strategy for reentry into the school setting**.

_____ I certify that the above student needs to be placed on **Intermittent Medical Homebound. The student is required to attend school a minimum of fifty percent (50%) of the time when placed on intermittent medical homebound (non-compliance can result in unexcused absence).**

_____ I certify that the above student cannot attend school because of illness or accident, even with the aid of transportation but may profit from instruction given in the home or hospital as of this date. (R**equests may not exceed 90 days. If the student is unable to return after 90 days, a new form must be submitted) *subject to 45-day review.**

Beginning Date: _____/_____/_____of Non-Attendance. **Projected Return Date** _____/_____/_____ **(Undetermined or Indefinite are not acceptable, requests may not exceed 90 days. If the student is unable to return after 90 days, a new form must be submitted.**

Printed Name: _____Physician's Signature: _____Date:____/_____/_____

Address:_____ Phone # _____

SECTION III – RELEASE: (To be completed by parent/guardian .)

I authorize the release of medical, educational, or mental health information to school officials.
._____ Date: _____/_____/_____

Signature of Parent/Legal Guardian/Surrogate Parent

SECTION IV – AUTHORIZATION: (To be signed and dated by the Building Administrator)

I approve the above request and I am forwarding this request to the District Superintendent or Designee for authorization. I understand that this medical condition may qualify the student as a student with a disability under Section 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act and that a referral to these processes will be made, if needed. If the student is already covered under either of these Acts, the student's team will meet to review and/or revise the 504 Plan or IEP to address the student's change in educational needs.

Building Administrator's Signature: _____ Date: _____/_____/_____

[ ] Approved [ ] Denied (letter to be sent to parent) _____**Date:** ____/_____/_____

District Office Signature

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MEDICAL HOMEBOUND PHYSICIAN AUTHORIZATION FORM FOR PREGNANT STUDENTS

Dear Physician*:*

Thank you for your dedication in keeping students in South Carolina healthy and progressing academically and socially in the regular school environment to the extent that is appropriate. The below named student and his/her parent, legal guardian, or surrogate parent has requested that the school district provide medical homebound instruction due to the student's inability to come to school as a result of pregnancy. A district representative may contact you to discuss strategies to maintain the student in the school environment and to request additional information. The district superintendent or his/her designee must approve any student participating in a program for medical homebound instruction or hospitalized instruction. **Please complete Section II as indicated.**

Any medical questions should be addressed to Tammy Trulove, Director of Health and Safety Services at (843) 488-6805.

SECTION I – STUDENT INFORMATION: (To be completed by school district personnel)

Student's Name:	Date of Birth:	Age:	Grade:
School:	School Year: **2014-2015**	Is this student classified as disabled? Yes____ No____ Area of Disability_____	
Last Date of Pupil Attendance: ____/____/_____ Number of Absences to Date: _____ Does the student currently have an Attendance Intervention Plan (AIP)? Yes ☐ No ☐ Is the student currently enrolled at HCEC? Yes ☐ No ☐			

SECTION II – MEDICAL INFORMATION: (To be completed by a ***licensed physician***)

Diagnosis or condition that **prevents** school attendance: (Attach additional information if needed).

Expected Date of Delivery _____/____/_____. (**Parent, guardian or student is responsible for notification of delivery to base school).**

[ ] **Uncomplicated** – Student is able to remain at school until delivery. Homebound instruction to begin as soon as possible after delivery and **will not exceed six (6) weeks.**

[ ] C**omplicated** - Does condition prevent student from attending school? **[ ] Yes [ ] No**

[ ] PIH – Pregnancy Induced Hypertension [ ] Placenta Previa [ ] Pre-Eclampsia [ ] Premature Labor
[ ] Hyperemesis [ ] Multiple Gestation [ ] PROM – Premature Rupture of Membrane
[ ] Other _____.

Projected Return Date _____/_____/_____ **(Undetermined or Indefinite are not acceptable, requests may not exceed 90 days)) *subject to 45-day review. If the student is unable to return after 90 days, a new form must be submitted. In order to qualify for Homebound Services, the student must have noted complication.**

_____ I certify that the above student needs to be placed on **Intermittent Medical Homebound. The student is required to attend school a minimum of fifty percent (50%) of the time when placed on intermittent medical homebound (non-compliance can result in an unexcused absence).**

_____ I certify that the above student cannot attend school because of pregnancy, even with the aid of transportation but may profit from instruction given in the home or hospital as of this date.

Printed Name: _____Physician's Signature: _____Date:____/_____/_____

Address:_____ Phone # _____

SECTION III – RELEASE: (To be completed by parent/guardian)

I authorize the release of medical, educational, or mental health information to school officials.
._____ Date: _____/_____/_____

Signature of Parent/Legal Guardian/Surrogate Parent

SECTION IV – AUTHORIZATION: (To be signed and dated by the Building Administrator)

I approve the above request and I am forwarding this request to the District Superintendent or Designee for authorization. I understand that this medical condition may qualify the student as a student with a disability under Section 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act and that a referral to these processes will be made, if needed. If the student is already covered under either of these Acts, the student's team will meet to review and/or revise the 504 Plan or IEP to address the student's change in educational needs.

Building Administrator's Signature: _____ Date: _____/_____/_____

[ ] Approved [ ] Denied (letter to be sent to parent) _____**Date:** ____/_____/_____
District Office Signature

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DETERMINATION OF INSTRUCTIONAL SERVICES

The following information must be completed by school personnel, in collaboration with the parent, upon receipt of a completed Medical Homebound Instruction form (HB-1).

SECTION I – STUDENT INFORMATION:

Student's Name:	School:	Date of Birth:	Age:	Gender:	Grade:
Parent/Guardian Name:	Address:		Phone:		

SECTION II – INSTRUCTIONAL SERVICES:

A. The student is currently enrolled in the following courses/classes. **A copy of the schedule in PowerSchool must be attached.**	**B.** The following courses/classes will be delivered during the medical homebound placement.*	**C.** Describe the accommodations and/or modifications to be made to the delivery of the courses listed in column B.*

* For students with disabilities, a copy of the IEP may be attached to fulfill the requirements of Column B and C.

SECTION III – TYPE AND AMOUNT OF INSTRUCTIONAL SERVICES:

☐ The student requires the provision of **regular** education services: _____ # of hours/week

☐ The student requires the provision of **special** education services: _____ # of hours/week **(must match Section IX of the IEP)****

**For students with disabilities, a copy of the IEP must be attached to evidence the type and amount of special education and related services to be provided.

_____ Date: _____/_____/____
Principal/Designee Signature

_____ Date: _____/_____/____
Parent/Guardian Signature

cc: Parent
Homebound Instructor

Signed original remains at the school

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PARENT EXPECTATIONS FOR MEDICAL HOMEBOUND SERVICES

I. STUDENT INFORMATION (Please Print)

Student's Name:	Date of Birth:	Age:	Gender:	Grade:
School:	School Year: **2014-2015**	Is this student classified as disabled? Yes____ No____ Area of Disability_____		

II. PARENT/GUARDIAN EXPECTATIONS: Please read carefully and complete with signature and date.

- I understand that eligibility is based on SC State Board of Education Regulation 43-241 and that the physician's statement is one (1) part of the information used to determine eligibility.
- I understand that my child must be enrolled in Horry County Schools prior to consideration for medical homebound services.
- I understand that Horry County Schools medical homebound personnel may contact the licensed physician to obtain information needed to determine if my child will be eligible for medical homebound services and/or if accommodations/modifications can be made to allow the student to attend school.
- I understand that medical homebound services are for students who **cannot attend school** due to a mental or physical condition due to an accident, an illness, or complications from pregnancy.
- I understand that if the school/district receives information that indicates a change in circumstances/eligibility during the term of my child's medical homebound placement (i.e. the student is employed, the student is no longer medically confined to the home, etc.) that a review of my child's medical homebound eligibility may be conducted by District Coordinator of Homebound Services and that my child may be subject to dismissal from medical homebound services to return to school.
- I understand that if my child is found eligible for **Intermittent Medical Homebound** services, she/he may come in and out of medical homebound instruction when ill. The District **requires the student to attend school a minimum of fifty percent (50%) of the time when placed on intermittent medical homebound**. **(Non-compliance can result in documentation as an unexcused absence).**
- I understand long term requests or requests involving a mental health condition are subject to a forty-five (45) day renewal and/or review by the District Review Team. **A letter will be sent regarding the 45-day renewal period**.
- I understand that homebound instruction is temporary; therefore requests should not be in excess of 90 days. An extension of services may be requested; however, this request must be documented on an updated Medical Homebound Physician Authorization Form from the student's attending physician. **I understand that it is my responsibility to obtain the necessary documentation and provide it to the homebound coordinator at the school**. **I also understand that any request for homebound services is subject to a 45-day review.**
- I understand that if homebound services are requested due to pregnancy; the Physician must document a complication that requires the student to receive homebound services.
- I understand that internet access may be necessary at the location selected for homebound services to be delivered.
- I understand that the instructor is responsible for instructional assignments for the approved dates of medical homebound services indicated by the physician on the homebound request. Any additional information or assignments prior to homebound approval are the responsibility of the parent and must be obtained from the school.
- I understand that all schedules and appointments must be met and, unless previous arrangements have been made with the instructor, that failure to adhere to the schedule/appointment may result in an unexcused absence for my child.
- I understand that if my child is found eligible for medical homebound services, she/he is subject to the same **mandatory attendance requirements** as other Horry County Schools' students.
- I understand that my child is responsible for submitting all instructional assignments and projects by the date set by the teacher.

❖ ❖ ❖

I have read and agree to comply with the homebound policies and procedures and understand the reasons for possible dismissal from the program. Additionally, I understand that failure to adhere to these expectations may result in the student's dismissal from homebound services.

_____ _____ ____/_____/____
Parent/Guardian Signature Print Name Date

cc: Parent

Signed original remains at the school.

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EXPECTATIONS FOR MEDICAL HOMEBOUND SERVICE PROVIDERS

I. STUDENT INFORMATION: (Please Print)

Student's Name:	Date of Birth:	Age:	Gender:	Grade:
School:	School Year: **2014-2015**	Is this student classified as disabled? Yes____ No____ Area of Disability_____		

II. TEACHER-RELATED SERVICE PROVIDER EXPECTATIONS: Please read carefully and complete with signature and date.

Personnel selected as instructors or related service providers for students receiving medical homebound services are expected to comply with all district policies, rules and regulations. In addition, homebound instructors are responsible for completing the following duties:

- Scheduling, delivering and documenting services in collaboration with the school, parent and student;
- Contacting the parent to establish and document a mutually agreed upon schedule for services to be provided;
- Instructing the student on the scheduled date and time; notify the school's Homebound Coordinator if the student is not participating in homebound instruction. After 1 week or 3 attempts to schedule services without success, notify the school's Homebound Coordinator.
- Consulting with the student's teacher(s) of record to obtain all appropriate instructional materials and course/subject requirements. Instruction will be provided for assignments occurring during the approved dates of medical homebound services indicated by the physician on the homebound request. Any additional information or assignments prior to homebound approval are the responsibility of the parent and must be obtained from the school.
- Maintaining on-going communication and collaboration with the teacher(s) of record regarding all the student's assignments, projects, tests and grades; notify the school's Homebound Coordinator if the student is not turning in assignments or projects as instructed.
- Entering all services information, including student absences, into the HOBO system within the required timeframe; **not to exceed 14 days from time of service.**
- Notifying the school's homebound coordinator if services are unable to be provided as documented;
- Securing parental signatures for all services provided; and
- Submitting service logs and travel within the required timeframe to the school's homebound coordinator for verification and processing; **not to exceed 30 days from time of service. Any logs or mileage received after 30 days will be subject to review by the District Coordinator.**

III. LOCATION AND SCHEDULE OF SERVICES:

I have collaborated with the parent and we have scheduled services according to the following schedule. I understand this schedule will be followed unless other arrangements have been made by and between the parent and me.
Days: M T W Th F S Su Times:
Location:

❖ ❖ ❖

I have read the expectations set forth above, I have received a copy of the Determination of Instructional Services (HB-1, page 3) for this student, I have scheduled services in collaboration with the parent, and I understand my responsibilities as assigned.

_____ _____/_____/_____
Employee's Signature Date

Signed original remains at the school.

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PARENTAL DISMISSAL OF MEDICAL HOMEBOUND SERVICES

I. STUDENT INFORMATION (Please Print)

Student's Name:	Date of Birth:	Age:	Grade:	School:
School:	School Year: **2014-2015**	Parent' Name: Parent Phone Number:		

III. Date:_____

IV. Homebound Hours Remaining: _____

IV. Reason for Dismissal of Remaining Hours:

V. I agree to dismissal of the remaining homebound hours for _____.
(student's name)

_____ _____ ___/___/__
Parent/Guardian (Signature) Print Name Date

_____ Date: ___/___/__
Homebound Coordinator Signature

cc: Parent
Homebound Instructor

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RETURN TO SCHOOL AFTER MEDICAL HOMEBOUND SERVICES

I. STUDENT INFORMATION (Please Print)

Student's Name:	Date of Birth:	Age:	Grade:	School:
School:	School Year: **2014-2015**	Parent' Name: Parent Phone Number:		

V. Dear Dr._____

VI.

Your patient_____is reentering the Horry County School District after a medical related absence. We need information concerning his/her health status. Please complete the information requested below:

VII. PERMISSION TO RETURN TO SCHOOL

_____can return to school on _____.

CURRENT DIAGNOSIS and MEDICAL STATUS: (additional information can be attached to this form).

_____
_____
_____

_____
Physician Signature Date

VIII. RECOMMENDATIONS FOR STUDENT INTEGRATION INTO THE SCHOOL SETTING

Activity Restrictions_____

Nutritional/Dietary_____

Adaptive Physical Education_____

Occupational Therapy_____

Physical Therapy_____

Special Procedures_____

If medications are to be administered at school, please complete a Permission to Administer Prescription Medication Form.

Form completed by Dr. _____

Print Dr. Name here: _____ ***Date*** _____

Address _____ ***Office #*** _____ ***Fax. #*** _____

_____ _____ ____/_____/____
Parent/Guardian Signature Print Name Date

cc: Parent

Signed original remains at the school

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PROVIDER DOCUMENTATION OF ATTEMPTS TO SCHEDULE HOMEBOUND SERVICES WITH PARENT/GUARDIAN

I. STUDENT INFORMATION (Please Print)

Student's Name:	Date of Birth:	Age:	Grade:	School:
School:	School Year: **2014-2015**	Parent' Name: Parent Phone Number:		

II. Date Homebound Assignment Received_____

III. Total Hours to be Served_____

IV. Initial Contact to Set-Up Services with Parent _____
(Date)

☐ PHONE _____ DATE/TIME ☐ E-MAIL _____ DATE/TIME

_____ DATE/TIME _____ DATE/TIME

_____ DATE/TIME _____ DATE/TIME

***After 1 week or 3 attempts to schedule Homebound sessions with parent, notify school-based coordinator.**

☐ **Contact School-based Homebound Coordinator** _____ **(DATE/TIME)**

☐ **Contact District-level Homebound Coordinator** _____ **(DATE/TIME)**

PLAN:

_____
_____
_____

☐ **SERVICES REVOKED**_____ DATE/TIME ☐ **SERVICES RE-INSTATED**_____ DATE/TIME

_____ ____/____/____
Homebound Coordinator Signature Date

cc: Parent
Homebound Instructor

Signed original remains at the school