Danville Public Schools

2022-2023

HOMEBOUND INSTRUCTION

MEDICAL RE-CERTIFICATION OF NEED

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 healthcare facility**" means the student is temporarily 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 extracurricular 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).
*To be completed by the licensed physician or licensed clinical psychologist providing care to the student for the condition for which the services are requested.**

1. Name of Student:____D.O.B___________________
2. Name of School:____Grade:__________________
3. Name of Doctor__________________________________Office phone number___________________
4. Nature and extent of illness:
____
____
5. Date of examination or diagnosis of this illness: ____
6. Is the student confined at home or in a healthcare facility? ❑ YES ❑ NO
7. Is the illness/treatment intermittent in nature (e.g., sickle cell anemia, chemotherapy for childhood cancer)?
8. Justification for extension of homebound instruction:
____
____
9. Specific steps planned to return the student to classroom instruction:
____
____
10. Additional time homebound instruction is anticipated (not to exceed 9 weeks per certification. list specific date):

    From Date: ____________________ Estimated date of return to school:__________________________
11. Explain progress towards ongoing treatment and/or therapy being and any changes in amount and kind of activity for the student during extended homebound instruction.
____
____
12. Frequency of treatment: ____

____ ____________________________

Signature of Licensed Physician/Clinical Psychologist **Date**

____ ___________________________

Print Physician/Psychologist Name **Telephone Number**

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Office Address City, State and Zip Code