



**Referral for Adjustment of Educational Program**

rev 1-2019

Some students need adjustments to their educational school program due to medical, physical or psychiatric conditions. In these unique instances, instruction may be provided in the home, hospital or treatment center setting. Please complete this form for your student/patient who may meet these distinctive conditions.

Section 1 is to be completed by the **parent, nurse or homebound coordinator** at the attendance school.

Sections 2, 3 and 4 are to be completed by the **Physician**. These sections may be completed by a physician licensed to practice medicine in all of its branches, licensed physician's assistant or licensed advanced practice nurse.

Section 5 is to be completed by the **School Nurse**.

*AN UPDATED MEDICAL REFERRAL WILL BE REQUIRED EVERY ONE TO THREE MONTHS DEPENDING ON THE NATURE AND EXTENT OF THE CHILD'S PRESENTING CONDITION. ALL SECTIONS MUST BE COMPLETED BEFORE THE FORM WILL BE REVIEWED AND CONSIDERED.*

Send the **Medical Referral, Teacher Application, and Teacher Acknowledgment** to the Home and Hospital Instruction Program via Google form.

**1. STUDENT INFORMATION (completed by the School Nurse or School Homebound Coordinator)**

Student's Name \_\_\_\_\_ School Name \_\_\_\_\_  
 Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Completed by \_\_\_\_\_ CPS ID# \_\_\_\_\_  
 Grade \_\_\_\_\_ Parent or Guardian \_\_\_\_\_  
 Home Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
 Home Address \_\_\_\_\_ Home Email Address \_\_\_\_\_

**2. PHYSICIAN INFORMATION (completed by the Physician)**

Physician's Complete Name (Print) \_\_\_\_\_ Physician's NPI \_\_\_\_\_  
 Physician's Specialty (area of practice) \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ Physician's E-Mail \_\_\_\_\_  
 Hospital(s) Affiliation(s) \_\_\_\_\_  
 Physician's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**3. STUDENT ELIGIBILITY (completed by the Physician)**

Date of Most Recent Medical Examination \_\_\_\_\_  
 Diagnosis Affecting School Attendance \_\_\_\_\_  
 Pertinent Information Which Includes How the Student's Medical Condition Affects the Student's Ability to Attend School  
 \_\_\_\_\_  
 \_\_\_\_\_





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Specify Ongoing Treatment and/Interventions for condition that precludes the student's attendance in school \_\_\_\_\_

Medications \_\_\_\_\_

**Pregnancy-Related Condition(s)**- Students who are pregnant are not eligible for homebound instruction unless there are complications associated with the pregnancy, such as toxemia or miscarriage.

Anticipated Delivery Date \_\_\_\_\_ Actual Delivery Date \_\_\_\_\_

Complications Associated with Pregnancy/Delivery? (Please Check One Box)  Yes  No

If yes, specify the complications \_\_\_\_\_

Health of the Baby \_\_\_\_\_

**Postpartum/Aftercare**-Typically, students return to school after six (6) weeks of homebound instruction unless there were delivery complications, such as a Cesarean section.

**4. TEACHING INSTRUCTIONAL DELIVERY SITE (COMPLETED BY THE PHYSICIAN). SELECT THE APPROPRIATE TEACHING SITE FOR THE STUDENT. INDICATE THE ANTICIPATED DURATION OF THE STUDENT'S ABSENCE.**

**Hospital Teaching**       **Treatment Center Teaching**       **Homebound Teaching**       **Intermittent Home Teaching**

Facility \_\_\_\_\_  
Name \_\_\_\_\_  
Student is hospitalized for an acute or chronic medical condition

Facility \_\_\_\_\_  
Name \_\_\_\_\_  
Student has been placed by the district or a court system

Student is anticipated to be to be absent

Student is chronically ill and may be absent periodically throughout the year

Start Date \_\_\_\_\_  
End Date \_\_\_\_\_

Start Date \_\_\_\_\_  
End Date \_\_\_\_\_

Start Date \_\_\_\_\_  
End Date \_\_\_\_\_

Start Date \_\_\_\_\_  
End Date \_\_\_\_\_

**5. SCHOOL NURSE INFORMATION (completed by School Nurse)**

I \_\_\_\_\_ (print name of the school nurse) reviewed all sections of the referral form and consider the information to be complete and correct.

I \_\_\_\_\_ (check one)  Agree  Disagree with the need for homebound instruction.

Date reviewed by School Nurse \_\_\_\_\_

School Nurse's signature \_\_\_\_\_

