Gray Collegiate Academy

MEDICAL HOMEBOUND INSTRUCTION FORM

Dear Provider:

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, accident, or pregnancy 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 fully complete Section II as indicated.

Section I – Student Information: (To be completed by School District Personnel)

Student's Name:	Date of Birth:	Age:	Grade:
School:	School District: **Charter Institute of Erskine**	Is this a student with a disability? Yes☐ No☐	Category of Disability:

Section II – Medical Information: (To be completed by a licensed physician, nurse practitioner, in compliance with the requirements of the Nurse Practice Act, or physician assistant in compliance with the requirements of Article 7 of the Medical Practice Act.)

Diagnosis of Condition that **prevents** school attendance:(Attach additional information if needed)

Prognosis and Treatment:

How does this medical condition impact educational performance and access to the student's educational program?

Beginning Date of Nonattendance: _____ **Projected Return Date:** _____

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

Phone#: **Address:**

Date: _____

Provider's Printed Name And Title: _____ **Provider's Signature:** _____

Section III – Release: (To be completed by parent or by student, if eighteen or older.)

I authorize the release of medical, educational, or mental health information to school officials.
Date:
Signature of parent/legal guardian/surrogate parent/or student if eighteen or older:

Section IV – Authorization: (To be signed and dated by the District Superintendent or Designee.)

I certify that school officials will consider whether the student now qualifies under Section 504 of the Rehabilitation Act of 1973 or is eligible for entry into programs for children with disabilities. I further certify if this is a student with a disability in accordance with State Board of Education regulations and if the student's medical homebound placement constitutes a change of placement, an IEP committee with parental involvement will develop an individualized education program (IEP). Medical homebound services are authorized to begin on or after date:
Superintendent's or Designee's Signature:

The need for medical homebound instruction may be reviewed periodically. School districts must retain this document on file for a period of five (5) years in accordance with procedures set forth in the South Carolina Pupil Accounting System Instruction Manual.

**Physician MUST choose one of the following:
_____**INTERMITTENT** _____ **FULL-TIME**