

Referral for Adjustment of Educational Program

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



**ODLSS**Office of DIVERSE LEARNER
SUPPORTS + SERVICES**Referral for Adjustment of Educational Program**

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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**Facility _____
Name _____Student is hospitalized for an acute
or chronic medical condition

Start Date _____

End Date _____

☐ **Treatment Center Teaching**Facility _____
Name _____Student has been placed by the district
or a court system

Start Date _____

End Date _____

☐ **Homebound Teaching**Student is anticipated to be
to be absent

Start Date _____

End Date _____

☐ **Intermittent Home Teaching**Student is chronically ill and may be
absent periodically throughout the year

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 _____

