**Alachua County Public Schools**

# Homebound or Hospitalized Medical Certificate

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|---|
| Student Name: ______________________________ Today's Date: ______________ |
| Student #: ______________ School: ______________ Grade: ________ |
| Date of Birth: ____________ Sex: ______ Race: _____ Primary Language at Home____________ |
| Parent/Guardian Name: ______________________________ |
| Parent/Guardian Address: ______________________________ |
| Parent/Guardian Home Phone: __________ Work Phone: __________ |

1. Please state the student's medical diagnosis and describe the physical or psychiatric condition.

   ______________________________

   ______________________________

2. What medical implications, if any, exist for instruction?

   ______________________________

   ______________________________

3. Is the student chronically ill or expected to have repeated intermittent illness due to a persisting medical problem? ( ) Yes ( ) No
   If yes, can the student be alternately assigned to Homebound or Hospitalized Program and to a school-based program? ( ) Yes ( ) No

4. I certify that the above identified patient:

   ☐ yes ☐ no Is expected to be absent from school due to a physical or psychiatric condition for at least fifteen consecutive days, or due to a chronic condition for at least fifteen school days which need not run consecutively.

   ☐ yes ☐ no Is confined to home or hospital.

   ☐ yes ☐ no Will be able to participate and benefit from an instructional program.

   ☐ yes ☐ no Is under medical care for illness or injury which is acute, or catastrophic in nature.

   ☐ yes ☐ no Can receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact.

5. Describe the treatment plan, recommendations and *expected date* for school re-entry.

   ______________________________

   ______________________________

______________________________
Physician's Name and title (please print)

______________________________
Physician's Signature

______________________________

______________________________
Address

______________________________
Phone Date

Form #: ESE 045.008 – Homebound & Hospitalized Medical Certifcate.doc/ESE/Forms
Revised Date: 8/21/07

Distributions: White - School
Pink - Cum Folder
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