Date Received by Enrollment School: ____________

APPLICATION FOR INSTRUCTIONAL PROGRAM
FOR HOMEBOUND OR HOSPITALIZED STUDENTS HOME AND HOSPITAL PROGRAM

Baltimore County Public Schools
6229 Falls Road, Baltimore, MD 21209
Telephone 443-809-3222
Email hhreferrals@bcps.org

PROFESSIONAL STATEMENT PHYSICAL/PREGNANCY CONDITION- SY 2021-2022

NOTE: All portions of this professional statement must be completed for Home and Hospital instructional services to be considered. All signatures are required for processing.

Please indicate credentials: ☐ Pediatrician ☐ Obstetrician ☐ Nurse Practitioner ☐ Specialist (Please indicate)
(*A Physician Assistant or Midwife may NOT be the sole signature on this Professional Statement. Only a psychiatrist, licensed psychologist, or school psychologist may certify EMOTIONAL conditions using the Emotional Professional Statement. *)

Name of Student: ______________________________ Sex: ☐ Male ☐ Female Date of Birth: _____
Address: ____
____ Zip Code: ________
School: ____ Grade: ______
Doctor's Name (please print): ____
Office Telephone Number: ____________________ Office Fax Number: ____________________
Office Address: ____
____

I. Medical diagnosis/condition:
____
____

*Date of Last Examination: ________________ For Pregnancy, Due Date: ________________
*Is the student seen on regularly scheduled visits to your office? ☐ Yes ☐ No
Frequency of visits: ____________________ Date of last visit: ________________________
*Is the student currently on medication? ☐ Yes ☐ No
*If Yes; Medication(s)/Dosage(s) ____
____
How will the medication(s) affect school performance?______________________________
____
____

*Impact on School Attendance (Description of how the impact precludes the student from attendance at the school of enrollment.)

☐ Immune Suppression
☐ Fatigue
☐ Medically restricted activity; Describe: ______________________________
☐ Pain

☐ Other; Describe: ____

*Recommended type of program for student:

☐ **<u>Full Time Physical</u>** - (*For a student anticipated to be **<u>continuously</u>** absent for 20 or more school days*)* ***Must complete Part II***

☐ **<u>Full Time Pregnancy</u> -** *(*Students are eligible to receive Home and Hospital instruction one week prior to the anticipated due date and may continue receiving instruction six weeks post-delivery*)*

☐ **<u>Chronic/Intermittent</u>** – *(*For a student anticipated to be **<u>intermittently</u>** absent due to a verified chronic condition throughout the school year*)* ***Do not complete Part II***

II. Full Time Physical Program ONLY –

Anticipated Length of Absence from School: ________________ (request must not exceed 60 calendar days)

<u>If more time is required, re-verification of condition is required prior to the expiration date</u>

III. Any restrictions on activity for school program? ☐ Yes ☐ No

*****If yes, please describe the restrictions. ____

____

____

IV. Does the student have a contagious condition? ☐ Yes ☐ No

*If yes, please describe the condition and needed precautions for teachers:

____

____

NOTE: By signing this statement, I certify that:

- **I am currently treating the above-named student.**
- **This student is not able to attend the regular day-school program with modifications because of his/her medical condition.**
- **I understand that students approved for the full-time Home and Hospital instructional services with a tutor typically receive 6 hours of instruction per week and that these services are the student's sole source of instruction—not a supplemental tutoring service.**

MD/NP Signature: __________________________________ Date: _________________________

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As the parent/guardian of the above student, I give my permission for my son/daughter to be referred to the Home and Hospital Program and when necessary, for the administrator, or his/her designee, to contact the physician above in reference to the medical condition(s) necessitating this referral. I am aware additional medical information may be required, as needed.

Signature of Parent/Guardian: ______________________________________ **Date:** ___________

E-mail Address: ____

Phone Numbers: (H) __________________ **(W)** __________________ **(C)** __________________

For Home and Hospital Use Only

Date Received:____________________

Date Assigned:____________________

Rev. 07/2021