



Homebound-Hospital Education Center

475 Corporate Square Drive, Winston-Salem, North Carolina 27101
Phone: (336) 727-2083 Fax (336) 661-3079 LEA 340394

Physician's Referral for Homebound Services for Parenting Student with Medically Fragile Child

Student's Last Name _____ Student's First Name _____
Student Number _____ Date of Birth _____
School of Record _____ Grade _____

I authorize my child's doctor, _____ to complete this medical referral and to

release appropriate medical information needed to request homebound/ hospital instructional services for me. In addition, the homebound staff may release appropriate homebound services/ instructional information to my child's doctor.

Parent Signature _____ Date _____

NOTE TO PHYSICIAN: Please Read Carefully

The student named above is being considered for homebound instruction due to **his/ her/ child's medical condition**. For a **parenting student** to be considered for homebound instruction, her/ her child's medical condition must either:

- (a) Require that the student be at the hospital with his/ her hospitalized child several times each week during school hours or
- (b) Prohibit the student's non-hospitalized child for whom the student is the only available daytime caregiver from attending group childcare.

The homebound program provides **temporary** instructional services in private homes for students who are referred from appropriate school system sources. Homebound instruction can never replace classroom learning. A parenting student is eligible for homebound services if the absence at home is anticipated to be at least four weeks.

Extending homebound services beyond six weeks requires a physician's reassessment of the student/ child's medical condition with **written recommendations/ treatment plan (Section 2/ 3)** sent to the Homebound/ Hospital Education Center Director. Fax 336-661-3079.

Student's child's name _____

Student's child's medical diagnosis _____

Does the student's child's medical condition prohibit school attendance by this student? _____ YES _____ NO

Do you recommend homebound instruction? _____ YES _____ NO

Anticipated date of return to school _____

Date of most recent assessment of the student's child's medical condition _____

Physician's Name _____ Physician's Signature _____ Date _____

Office Phone Number _____ Office Fax Number _____

Please email, hand deliver, or fax this form to Homebound- Hospital Education Center 336-661-3079