

# HARLINGEN CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

## GENERAL EDUCATION HOMEBOUND DOCTOR VERIFICATION OF NEED FOR HOMEBOUND INSTRUCTION

GEH-1

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ ID#: \_\_\_\_\_ Grade: \_\_\_\_\_ Campus: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Date of Physical Exam: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**DIRECTIONS:** This form must be updated at the beginning of ***EACH*** school year. Services are ***NOT*** automatically continued from one school year to another. This form is required to be completed before the consideration of GEH services will be granted. **Physician must complete this form in its entirety.**

☐ YES ☐ NO 1. The student has a ***medical condition*** that will result in confinement to his/her home or hospital for a minimum of four (4) consecutive weeks.

☐ YES ☐ NO 2. Has this student been recommended for a follow-up exam? If "YES", when?

Approximate length of confinement: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Describe the nature of the condition(s) resulting in the need for homebound services: \_\_\_\_\_

What are the criteria for the student returning to school? \_\_\_\_\_

List recommendations for the school's reintegration plan including an approximate timeline for student's return. \_\_\_\_\_

☐ YES ☐ NO 1. Does the student have a communicable disease that poses a risk to the homebound teacher becoming infected or carrying it to another student? If "YES", describe precautions that should be taken.

☐ YES ☐ NO 2. Is the student physically able to do school work with a homebound teacher? If "NO", explain:

☐ YES ☐ NO 3. Is the student permitted to participate in any activities outside the home? If "YES", explain:

\_\_\_\_\_  
\_\_\_\_\_

☐ YES ☐ NO 4. If the student has not been totally confined to the home, is the student able to receive any instructional services on a general education campus (e.g., shortened school day)? If "YES", explain:

\_\_\_\_\_  
\_\_\_\_\_

List recommendations for the school's reintegration plan including an approximate timeline for student's return. \_\_\_\_\_

\_\_\_\_\_

What medication(s) is the student currently taking? \_\_\_\_\_

\_\_\_\_\_

What effects, if any, will the medications have on the student's learning? \_\_\_\_\_

\_\_\_\_\_

**IF HOMEBOUND INSTRUCTION IS RECOMMENDED, PLEASE CHECK THE FOLLOWING:**

☐ YES ☐ NO 1. This student is unable to function in the school setting, even for a shortened day at this time.

☐ YES ☐ NO 2. I recognize that homebound placement is a very restrictive educational placement that prevents the student from interacting with his/her peers.

☐ YES ☐ NO 3. My recommendation concerning educational placement is based on my professional medical evaluation of this student's condition.

**NOTE: All physician's orders expire on the last day of each school year** unless indicated for an earlier date of exit. General Education Homebound is **not** intended to be a long-term placement and cannot replicate the regular classroom and/or its experiences.

\_\_\_\_\_  
Signature of Licensed Physician

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
City, State Zip

\_\_\_\_\_  
Fax Number

Return form to the campus §504 coordinator: \_\_\_\_\_

Completed form due no later than: \_\_\_\_\_