APS Homebound Instruction – Medical Certification of Need

To be completed by the licensed physician, licensed clinical psychologist or licensed psychiatrist providing care to the student for the condition for which the services are requested.

PLEASE WRITE LEGIBLY

DOB: _____

Student Name: _____ Pronouns: _____ Examination date: _____

Please describe medical or psychiatric/psychological diagnoses or conditions which are currently impacting the student's ability to attend school in person:

_____

_____

_____

Please describe any ongoing treatment and/or therapy provided for the student:

_____

_____

_____

Frequency of treatment: _____ Estimated date of return to school: _____

Expected duration of impact on student attendance: ☐ < 6 weeks ☐ > 6 weeks ☐ intermittent ☐ unlikely to change

Is the student confined at home or in a health care facility? ☐ YES ☐ NO

In your estimation, if the school made accommodation, could this child attend school? ☐ YES ☐ NO

If **YES,** please indicate recommended considerations: (accommodations are made by IEP/504 teams based on educational impact)

- ◊ Small group instruction
- ◊ Arms-length supervision
- ◊ Crisis plan (Behavioral)
- ◊ Crisis plan (Medical)
- ◊ Extended time on assignments
- ◊ Extended time on tests
- ◊ Specialized lighting
- ◊ Frequent breaks
- ◊ Eat or drink on demand
- ◊ Visual schedule
- ◊ Daily check-ins with counselor or trusted adult
- ◊ Medication management
- ◊ Abbreviated school day / Flexible schedule
- ◊ Prompting / reminders
- ◊ Assist with organization and materials management
- ◊ Access to behavioral specialists
- ◊ Staff with training in best practices for students with ASD (autism spectrum disorder)
- ◊ Screen reader technology
- ◊ Reduced screen time
- ◊ Large medical equipment required on site (this would not include wheelchair, standers; examples might be hospital bed, IV / O2 supplies and lines)
- ◊ Environmental adaptations: _____
- ◊ Other: _____

Please provide a point of contact in your medical office / practice who can be available to respond to inquiry from the homebound coordinator or other designated party about the student's projected medical status, medical history, or symptoms that may impact educational access in the home or school environments:

_____

Name/Title Phone/Email

I hereby submit that the information provided on this form is accurate and provided in good faith for the determination of temporary educational services provided by Arlington Public Schools in a homebound setting for the student:

_____

Signature of Licensed Physician/Psychiatrist/Clinical Psychologist Date

_____

Print Physician/Psychologist/Psychiatrist Name Date

_____

Office Address City, State and Zip Code Phone Number

Homebound instruction shall be made available to students who are confined at home or in a health care facility for periods that would prevent normal school attendance (8VAC20-131-180). The term "**confined at home or in a health care facility**" means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment. Students receiving homebound instruction may not work or participate in extra-curricular activities, non-academic activities (such as field trips), or community activities unless these activities are specifically outlined in the student's medical plan of care or the Individualized Education Program (if applicable).