Lee County School System
Referral for Hospital-Homebound Services

I. Student Information:

Name: _____ Date of Birth _____ M F

Parent/Guardian Name:_____

Address: _____

Home Phone: _____ Cell Phone: _____

Is there a computer in the home? _____ Do you have internet access? _____

Parent email address: _____

Last date student attended school: _____

II. School Information

System: _____ School: _____ Teacher: _____

Counselor: _____ Phone: _____ Grade: _____

Is the student served by: ☐ 504 ☐ IEP ☐ Regular Education

The school/district retains all responsibility for providing assignments and grades to the student while the student is enrolled.

III. Medical Information

Diagnosis: _____

Authorized Prescriber's Name (please print): _____

GA License #: _____ Phone: _____ Fax: _____

Does the student have a communicable disease? _____

Can the student participate in and benefit from an instructional program? _____

Please review the accompanying Medical Report Form and/or letter for additional information.

IV. Services Recommended (check one):

☐ Full Time ☐ Intermittent ☐ Hospital Only

Starting Date: _____ Ending Date: _____

V. Certification:

I request Hospital/Homebound (HHB) services for my child. I hereby give permission for the attending licensed physician or licensed psychiatrist for the diagnosis presented to communicate information regarding my child's medical/emotional condition for which he/she is referred.

Parent/Guardian: _____ Date: _____

By signing below, I certify that HHB services are requested, medically necessary and appropriate for this student.

Signature of Authorized Prescriber: _____ Date: _____

By signing below, I certify that this student meets school eligibility requirements for HHB services.

Homebound Coordinator: _____Date: _____