**MEDICAL HOMEBOUND INSTRUCTION FORM**

*(Return to: Office of Student Services, Attention: Jayne C. Lee-Director, 1738 Highway 301 North, Dillon, SC 29536)*

**Dear Physician:**

**Thank you for your dedication in keeping students in South Carolina healthy and progressing academically and socially in the regular school environment to the extent that is appropriate. The below named student and his/her parent, legal guardian, or surrogate parent has requested that the school district provide medical homebound instruction due to the student's inability to attend school as a result of an illness, accident, or pregnancy even with the aid of transportation. A district representative may contact you to discuss strategies to maintain the student in the school environment and to request additional information. The district superintendent or district designee must approve any student participating in a program for medical homebound instruction or hospitalized instruction.**

**Homebound instruction cannot be given to any student until a *Medical Homebound Instruction Form* has been completed by a licensed physician and returned to Dillon School District Four, Office of Student Services (843)774-1200.**

**SECTION I-STUDENT INFORMATION:** ***(School personnel MUST complete Section I)***

| **Student's Name:** | **Date of Birth** | **Age:** | **Grade:** |
|---|---|---|---|
| **School:** | **School District:**<br><br>**Dillon School District Four** | **Is this student classified as disabled?**<br><br>**Yes_____ No _____ Category _____** | |

**SECTION II-MEDICAL INFORMATION:** ***(A licensed physician MUST complete Section II)***

***Diagnosis of condition that prevents school attendance:** ***(Attach additional information if needed)***

***Prognosis and Treatment:**

***How does this medical condition impact educational performance?**

***Beginning date of nonattendance: _____ / _____ / _____ Projected return date: _____ / _____ / _____**

**I certify that the above student cannot attend school because of illness, accident, or pregnancy, even with the aid of transportation but may profit from instruction given in the home or hospital.**

***Physician's Signature: _____ *Printed Name: _____**

***Date: _____ / _____ / _____ *Phone#:_____ *Address:_____**

**SECTION III-RELEASE:** ***(A parent/guardian MUST complete Section III, unless the student is eighteen or older)***

**I authorize the release of medical, educational, or mental health information to school officials.**

**_____ Date _____ / _____ / _____**

**Signature of Parent/Legal Guardian/Surrogate Parent (or student if eighteen or older)**

**SECTION IV-AUTHORIZATION:** ***(To be signed and dated by the District Superintendent or Designee)***

**I certify that school officials will consider whether the student now qualifies under Section 504 of the Rehabilitation Act of 1973 or is eligible for entry into programs for children with disabilities. I further certify if this is a student with a disability in accordance with State Board of Education regulations and if the student's medical homebound placement constitutes a change of placement, an IEP committee with parental involvement will develop an individualized education program (IEP).**

**Medical homebound services are authorized to begin on or after: _____ / _____ / _____**

**Superintendent's or Designee's Signature: _____ Date: _____ / _____ / _____**

**DO NOT WRITE IN THIS SPACE – INFORMATION FOR HOMEBOUND INSTRUCTOR**

_____ Number of Days Approved for Homebound Services

**The need for medical homebound instruction may be reviewed periodically. School districts must retain this document on file for a period of five (5) years in accordance with procedures set forth in the South Carolina Pupil Accounting System Instruction Manual.** **Revised 7/28/15, supersedes all previous versions**