



**THE ATTACHED HOMEBOUND FORM WILL NOT BE
PROCESSED IF THIS NOTICE IS REMOVED**

Physician Please Read and Sign

Homebound instruction is available to a student who cannot attend school because of illness, accident, or pregnancy. Homebound instruction is appropriate when a student has a medical condition that confines the student to the home, hospital, or other facility approved by the district. **When you sign the attached form, you are certifying that the student cannot attend school but may profit from instruction given in the home, hospital, or other facility approved by the district.**

Once approved, *a student is eligible for homebound instruction* on the day following his/her last day of school attendance. If a student is unable to begin the school year, he/she is eligible for homebound instruction on the first day of the regular nine-month academic year of the school in which he/she would be enrolled. *The student remains eligible* until the day before he/she returns to school or until the last day of the regular academic year in the school where he/she would normally be enrolled, whichever occurs first.

Homebound instruction is not intended to be a substitute for regular school attendance. The revised district curriculum standards and the South Carolina Accountability Act of 1998 establish much higher expectations for student performance, and regular attendance is essential for success in school. A student who is approved for homebound instruction receives one (1) hour of instruction for each day of school missed. Homebound instruction is not offered for a course that requires equipment or specialized instructional materials not available where the homebound instruction is conducted.

Please help us provide a quality education for the students of Anderson School District Five. If you have questions, please call **Executive Director, Katie Brown at 864-260-5075. Forms may be faxed to 864-2605192.**

Physician's Printed Name

_____, M.D. or D.O. (Circle one)
Physician's Signature

MEDICAL HOMEBOUND INSTRUCTION FORM

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 come to 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 his/her designee must approve any student participating in a program for medical homebound instruction or hospitalized instruction. Please fully complete Section II as indicated.

SECTION I – STUDENT INFORMATION: (To be completed by school district personnel)

Student's Name:	Date of Birth:	Age:	Grade:
School:	School District:	Is this student classified as disabled?	
Yes No Category _____			
The student has access to <input type="checkbox"/> a Computer <input type="checkbox"/> the Internet			
Does the student currently have an Attendance Intervention Plan (AIP)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION II – MEDICAL INFORMATION: (To be completed by a *licensed physician*)

Diagnosis of condition that <u>prevents</u> 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: ____/____/____ ***Maximum approval period is 9 weeks*** (Extension requests will require submitting a new form.)
_____ 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 as of the date listed above. _____ I certify that the above student needs to be placed on Intermittent Medical Homebound. The student is required to attend school a minimum of fifty percent (50%) of the time when placed on intermittent medical homebound. *<input type="checkbox"/> Doctor, check here if this is an extension to a previous homebound. Date: ____/____/____ Phone # _____ Address: _____ Printed Name: _____ Physician's Signature: _____ M.D. or D.O. (Circle one) Practice Name: _____

SECTION III – RELEASE: (To be completed by parent or by student, if eighteen or older)

I authorize the release of medical, educational, or mental health information to school officials. Date: ____/____/____ Signature: _____

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 the 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).

Approved Date: ____/____/____ to ____/____/____ Not approved

Homebound Coordinator's Signature: _____

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.