JACKSON-MADISON COUNTY SCHOOL SYSTEM

Homebound Instructional Services Department
Attention: Hope Khalil, Lead Homebound Consulting Teacher
Scan to: hrkhalil@jmcss.org or Fax 731-664-2502
310 N Parkway, Jackson, TN ph:731-506-3484

MEDICAL REFERRAL FOR HOMEBOUND PLACEMENT

Name: _____ **DOB:** _____ **Sex:** _____ **Race**_____

School child attends: _____ **Grade:** _____

Name of Parent/Guardian: _____

Address: _____ **Phone:** _____

MEDICAL REPORT (To be filled out by attending physician ***only***)

Handicapping Conditions_____

Physical Limitations_____

Medical Treatment_____

Prognosis_____

Length of homebound time *recommended* (minimum of 11 days): _____

As a physician, you are a member of the child's multi-disciplinary team. Your reports and recommendations are important in determining **if** a homebound instructional program is necessary. The above medical information is needed so that a more effective educational program may be planned for the child, who has health conditions, which deter the child from attending school. **This is a confidential report and shall be used ONLY by those directly interested in the welfare of the child.**

A physician's signature is required (below) on this homebound request form.

_____ _____

Signature of Physician Printed Physician's Name

Name and address of Physician's Office/Clinic

Office/Clinic Telephone # _____ Date: _____

--For district use only--

Name of teacher assigned _____ Special ED _____ Case manager_____

Date instruction begins _____Date instruction ends _____ Return Date _____