JACKSON-MADISON COUNTY SCHOOL SYSTEM

Homebound Instructional Services Department
Attention: Hope Khalil – Director of Extended Learning
Email/Scan to: Hrkhalil@jmcss.org or Fax**:(731)664-2502 Att. Hope Khalil**

MEDICAL REFERRAL FOR HOMEBOUND PLACEMENT

Name: _____ **DOB:** _____ **Sex:** ____ **Race**___
Child's School: _____ **Grade:** __ **School Issued Device Yes** __ or No ___

Parent/Guardian: _____ **Address**: _____

Email: _____ **Phone:**_____
Alternate phone:_____

MEDICAL REPORT (To be completed *only* by attending physician)

Handicapping Conditions_____

Physical Limitations_____
Medical Treatment_____
Prognosis_____
Length of homebound time *recommended* (minimum of 11 days): _____
As a physician, you are part 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 necessary so a more effective educational program can 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 child's welfare.**

This homebound request form ***requires A physician's signature (below).***

_____ _____
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 _____