



JACKSON-MADISON COUNTY SCHOOL SYSTEM

Homebound Instructional Services Department

Attention: Paul J. Eichelkraut, Coordinator

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Phone: (731) 506-3056

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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 _____