HANOVER COUNTY PUBLIC SCHOOLS
Medical Certification of Need
2023-2024

Name of student:	Date:
Birthdate:	Parent/Guardian:

Homebound instruction shall be made available to students who are **confined** at home or in a health care facility for periods that would prevent normal school attendance (8VAC20-131-180). The term "**confined at home or in a healthcare facility**" means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, absences from home are infrequent, for periods of relatively short duration, or to receive health care treatment.

Delivery of homebound services may be delivered virtually or in person.

For students receiving services through a 504 Plan or Individual Education Plan (IEP), a 504 or IEP meeting must be scheduled to discuss any accommodations or services required.

Students receiving homebound instruction **may not** work or participate in extracurricular activities, non-academic activities (such as field trips, dances, senior events, etc.), or community activities unless these activities are specifically outlined in the student's medical plan of care or the Individualized Education Program (if applicable).

This section is to be completed by the licensed physician or licensed clinical psychologist providing care to the student for the condition for which the services are requested. Signature so Clinical Social Workers and counselors can not be accepted per state guidelines. *

Nature and extent of illness:		
Date of examination or diagnosis of illness:		
Is the student confined at home or in a healthcare facility?	o Yes o No	If student is confined to a Health Care Facility, provide facility name:
Does the student require accommodations to fully participate in instruction?		o Yes o No
If yes, please list accommodations:		
If no, please explain:		

Homebound Instruction will be required from _____ to _____.

(If it is necessary for homebound instruction to continue beyond nine weeks, an extension or reauthorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required.)

Explain ongoing treatment:
Frequency of treatment:

Signature of Licensed Physician/Clinical Psychologist	
Print Physician/Psychologist Name:	Date:
Office Address:	Office Telephone Number:

**Please fax the form to 804-752-4517 or email Stacy Stanford at sstanford@hcps.us.

*The *Code of Virginia* § 54.1-2957.02 states "whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a nurse practitioner."