

INSTRUCTIONS: This form is used by the Home and Hospital Teaching Office to obtain physician's recommendation and parent's permission to initiate instruction as appropriate. Completed form is maintained in the Home and Hospital Teaching Office.

Student _____ ID # _____ Sex: M F Date of birth ____/____/____
Last (PLEASE PRINT) First MI

Address _____
Street City State ZIP Code

Phone: Home _____ - _____ - _____ Work _____ - _____ - _____ Cell _____ - _____ - _____

School _____ Grade _____ Last day of school attendance ____/____/____
Present School or Last School Attended

Does the student have a 504 Plan IEP?

Parent/Guardian _____

Remarks _____

I authorize the MCPS school psychologist and/or school medical advisor to consult, when necessary, with the psychiatrist/psychologist attending my son/daughter to confirm the diagnosis. I am aware that MCPS has the right to withhold service until the need for home and hospital teaching has been confirmed.

_____/____/____
Signature, Parent/Guardian Date

PSYCHIATRIST'S/PSYCHOLOGIST'S STATEMENT:

Psychiatrist/Psychologist _____ Work phone _____ - _____ - _____

Address _____
Street City State Zip

This is to certify that the above named student was examined by me on ____/____/____ and is unable to attend school.
Date

I will I will not be responsible for the continuing of treatment or supervision during the time he/she is out of school.

A. Is this incidence of emotional distress so acute as to be critical to the child's emotional or physical well-being, taking into consideration the onset of the disorder and the length of time the student will be outside of the public sector? Yes No

B. If Home and Hospital Teaching (HHT) is recommended, please attach a brief report including the following: 1. Specific diagnosis and prognosis; 2. Medicine and dosage; 3. Reason HHT is recommended; 4. Treatment plan with criteria for return to school.

_____/____/____
Signature, Psychiatrist/Psychologist Date

Reviewed by the school psychologist:

_____/____/____
Signature, School Psychologist Date

Comments _____

SCHOOL PSYCHOLOGIST'S REFERRAL:

School Psychologist _____ Phone _____ - _____ - _____

Location _____ Recommended duration of HHT services _____

Comments _____

ADMINISTRATIVE ACTION:

Student has been approved to receive services through home and hospital teaching due to an administrative placement.

Recommended duration of service _____

_____/____/____
Signature, Associate Superintendent/Designee Date