



MIAMI-DADE COUNTY PUBLIC SCHOOLS
**REQUEST FOR CONSIDERATION OF ENROLLMENT IN THE
 HOMEBOUND/HOSPITALIZED INSTRUCTIONAL PROGRAM**
**SOLICITUD PARA CONSIDERAR INSCRIPCIÓN EN EL
 PROGRAMA DE INSTRUCCIÓN PARA ESTUDIANTES
 EN EL HOGAR U HOSPITAL**
**DEMAND POU KONSIDERE ENSKRIPSYON NAN
 PWOGRAM ENSTRIKSYON POU MOUN MALAD KI RETE
 LAKAY/OSPITALIZE**

Mail or Fax completed forms to: Llène el formulario y envíelo por correo o facsímile a: Ranpli fòm yo epi Poste oubyen fask yo ba: Merrick Educational Center 11001 SW 76 Street Miami, Florida 33173 Telephone: (305) 514-5100 Fax: (305) 447-3761
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To be considered for services from the Homebound/Hospitalized program, it is necessary that the referring physician and/or psychiatrist make a recommendation. The parent or legal guardian must sign below, releasing information from the physician/psychiatrist to the Miami-Dade County Public Schools Homebound/Hospitalized Instructional Program. The student will not be considered for the Homebound/Hospitalized Instructional Program without this signed release. **Incomplete forms will be returned.**

Es necesario que el médico y / o siquiatra del estudiante haga su recomendación para que pueda ser considerado para los servicios del programa de instrucción para estudiantes en el Hogar u Hospital. El padre, la madre o tutor legal debe firmar abajo, autorizando al médico y / o siquiatra a proveer información al Programa de Instrucción para Estudiantes en el Hogar u Hospital que ofrecen las Escuelas Públicas del Condado Miami-Dade. El estudiante no será considerado para el Programa de Instrucción para Estudiantes en el Hogar u Hospital sin que este formulario haya sido firmado. **Los formularios incompletos serán devueltos.**

Pou nou konsidere w pou resevwa sèvis nan pwogram pou Moun Malad ki Rete Lakay/Ospitalize, li nesesè pou doktè ak/ousnon sikyat la ba w yon rekòmandasyon. Paran an ousnon responsab legal la dwe siyen anba, pou ba doktè/sikyat la otorizasyon pou ba pwogram pou Moun Malad ki Rete Lakay/Ospitalize nan Lekòl Leta Miami-Dade County aksè ak enfòmasyon sa yo. Nou pap konsidere elèv la pou enstriksyon nan pwogram pou Moun Malad ki Rete Lakay/Ospitalize si fòm sa a pa siyen. **Nap retounen fòm ki pa fin ranpli.**

SECTION I - COMPLETED BY THE PARENT/LEGAL GUARDIAN

STUDENT NAME (last, first, middle)		STUDENT NUMBER	BIRTH DATE
ADDRESS (street number & name, apt. no., city, state, zip code)			
PARENT NAME (last, first, middle)		HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
SCHOOL			GRADE

I hereby authorize the physician to release all information concerning diagnosis, treatment and any medical implications for instruction to the Miami-Dade County Public Schools. This communication may be written or verbal. This release will remain in effect until the student has been dismissed from the Homebound/Hospitalized Instructional Program.

Por la presente autorizo al médico que proporcione a las Escuelas Públicas del Condado Miami-Dade, toda información con relación al diagnóstico, tratamiento y cualquier implicación médica con respecto a la instrucción del estudiante. Esta comunicación puede ser por escrito o verbal. Esta autorización permanecerá en vigor hasta que el estudiante sea retirado del Programa de Instrucción para Estudiantes en el Hogar u Hospital.

Mwen ba otorizasyon m pou doktè ba tout enfòmasyon konsènan dyagnostik, tretman ak nenpòt kondisyon medikal ba Lekòl Leta Miami-Dade County. Kominikasyon sa a ka pa ekri ousnon vèbal. Otorizasyon sa a pral rete valid jiska ke elèv la kite pwogram pou Moun Malad ki Rete Lakay/Ospitalize.

Must be signed by parent/legal guardian or _____	_____
student at the age of majority (18 years or older)	DATE
Debe ser firmado por el padre, la madre o tutor legal o _____	_____
el estudiante si es mayor de edad (18 años o mayor)	FECHA
Paran/responsab legal dwe siyen osnon _____	_____
elèv ki gen laj majè (18 an ousnon pi gran)	DAT

SECTION II - COMPLETED BY THE PHYSICIAN/PSYCHIATRIST

PHYSICIAN/PSYCHIATRIST NAME	PHYSICIAN/PSYCHIATRIST SPECIALTY	TELEPHONE NUMBER
PHYSICIAN/PSYCHIATRIST ADDRESS		

EXPECTED DATE OF RETURN: An anticipated date of return to school must be determined by the physician. If an undetermined date is indicated, the form will be returned to the physician and/or psychiatrist for an expected date of return. Returned forms will delay the consideration of a student's possible placement into the Homebound/Hospitalized Instructional Program. If, during treatment, the physician/psychiatrist needs to extend the expected date of return to school, the physician/psychiatrist may do so by submitting a new form which reflects the revised date of return. If the student can return to school prior to the expected date written below, a Physician's Release of Student Form will be required. The amended form or letter can be faxed to the Homebound/Hospitalized Instructional Program office, FAX number (305) 447-3761.

EXPECTED SCHOOL RETURN DATE (MANDATORY) _____ (mm/dd/yy)

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STUDENT NAME (last, first, middle)	STUDENT NUMBER
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Medical or psychiatrist diagnosis (attach additional sheets if necessary) **(please print)**

ELIGIBILITY: The licensed physician must certify that the student meets **all** of the following criteria for eligibility. Students who do not meet all of the minimum eligibility criteria listed below will not be eligible for the Homebound/Hospitalized Instructional Program. **All questions must be answered "yes" and initialed by the physician in order to certify eligibility.**

- | YES | NO | INITIAL | |
|--------------------------|--------------------------|---------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | 1. Is the student expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) consecutive school days or the equivalent on a block schedule? |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | 2. Is the student confined to the home or hospital? |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | 3. Will the student be able to participate in and benefit from an instructional program? |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | 4. Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature? |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | 5. Can the student receive instructional services without endangering the health and safety of the instructor or other students the instructor may come in contact? |

Students entering the Homebound/Hospitalized Instructional Program will be placed in the most restrictive educational and social environment where the student will not have physical contact with their peers during the school day.

- | YES | NO | INITIAL | |
|--------------------------|--------------------------|---------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | 6. Do you recommend the student be placed in this most restrictive environment? |

THE STUDENT REQUIRES (CHECK ONE):

- Continuous placement in the Homebound/Hospitalized Instructional Program
- Intermittent placement in the Homebound/Hospitalized Instructional Program
- Partial day at school _____ hours _____ days

TREATMENT PLAN AND OTHER INFORMATION (CHECK ALL THAT APPLY):

- Medication Management
- Surgical Management
- Post-surgical recovery
- Psychotherapy
- Chemotherapy
- Dialysis
- Frequent medical monitoring and follow up
- Hospitalization
- Bed rest
- Other _____
- Return to school will require _____

_____ SIGNATURE OF PHYSICIAN	_____ DATE
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Signature must be an original signature.
 Reproductions such as a stamp will not be accepted.