Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

Illinois State Board of Education

100 North First Street, N-253
Springfield, Illinois 62777-0001

MEDICAL CERTIFICATION FOR HOME / HOSPITAL INSTRUCTION

SPECIAL EDUCATION SERVICES DIVISION

INSTRUCTIONS: Complete this form and retain on file in the local school district. Do not submit this form to the State Board of Education, but make this form available for auditing purposes.

Students may need to be educated temporarily away from the school building due to a medical condition (physical or mental). When a student needs to be away from the school building for a minimum of two or more consecutive weeks of school or ongoing intermittent absences totaling 10 or more school days, the student may be eligible for instruction at home or in a hospital (or other setting) by a qualified teacher. (34 CFR 300.39 and 300.115 and Section 14-13.01 of the school code [105 ILCS 5/14-13.01(a)] and ISBE Rule 226.300). It is not necessary for the student to have an IEP or 504 plan to qualify, although either may be created depending on student need and school procedures.

Parents: Please return this form to your child's school district promptly as services cannot be started until medical information is received. Upon receipt of medical certification, the school district will provide home/hospital services for an eligible student.

**It should be noted that a child receiving homebound services is not eligible to participate in or attend extra-curricular activities as defined in the Parent/ Student Handbook.

SECTION 1 – THIS SECTION FOR SCHOOL DISTRICT USE ONLY

NAME OF STUDENT (Last, First, Middle)	GENDER ☐ Male ☐ Female	GRADE
STUDENT ADDRESS (Street, City, State, Zip Code)	NAME OF STUDENT PARENT OR GUARDIAN	
STUDENT DATE OF BIRTH	TELEPHONE OF STUDENT PARENT OR GUARDIAN (Include Area Code)	
DISTRICT NAME AND NUMBER	SCHOOL NAME	
DISTRICT ADDRESS (Street, City, State, Zip Code)	SCHOOL ADDRESS (Street, City, State, Zip Code)	
DISTRICT TELEPHONE (Include Area Code)	SCHOOL TELEPHONE (Include Area Code)	

SECTION 2 – TO BE COMPLETED BY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL ITS BRANCHES, APRN OR PA:

DIAGNOSIS (Please fill in the following):

Disease/Injury/Surgery (Primary diagnosis) _____

If disease, is the disease communicable? ☐ Yes ☐ No If yes, please provide instruction to school staff in the space below labeled "***Special Recommendation to Teachers***"

Drug/Alcohol Treatment _____

Pregnancy (Including Postpartum) _____

Mental Health/Emotional Health _____

Other (Please describe) _____

I certify that this student is unable to attend public school and is medically eligible and physically able to be enrolled in the following program

(Check (✓) one only) ☐ Home Instruction ☐ Hospital Class or bedside

The medical provider must estimate that the student will need the home or hospital instruction for a minimum of 10 school days this school year. The time may be longer than 10 days; if unable to determine approximate length of time, provider may estimate 'through end of school year' as long as the time period is at least 10 days.	Estimated length of time student will need home or hospital instruction this school year, if possible. (In weeks): _____

Special Recommendation to Teacher concerning diet, rest, exercise, positioning, etc.

_____
Type or Print Name of Physician, MD, DO, APRN or PA

_____
Provider Contact Telephone Number (Include Area Code)

SCHOOL DISTRICT USE ONLY:
Date home or hospital instruction began: _____

_____ _____
Original *Signature of Physician, APRN or PA* *Date*

Print Reset Form