Wakulla County Schools

HOSPITAL/HOMEBOUND MEDICAL CERTIFICATION

Part I

Student Name: _____ is under medical care and treatment for illness or injury for: (describe disabling condition or diagnosis)

☐ Physical

☐ Psychiatric

Part II

Please ✓

Condition is: ☐ Acute ☐ Catastrophic in nature ☐ Chronic ☐ Repeated intermittent illness due to persisting medical problem.

Student is unable to attend school and medical problem confines student to:

☐ Home ☐ Hospital ☐ Alternate homebound/hospital due to chronic intermittent condition

☐ Homebound, hospitalized/school-based program due to an acute, chronic, or intermittent condition.

☐ Student will be able to participate and benefit from an instructional program.

☐ Medical restrictions, implications for instruction and comments:

☐ To the best of my knowledge, this student can receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact.

Part III

Duration of absence from the regular school program is expected to be: (estimate of duration of condition or prognosis):

Part IV

Student Name: _____

Medical Treatment Plan: (briefly describe you treatment plan)

Part V

Recommendations regarding school re-entry

Part VI

Signatures: (Florida licensed medical doctor (MD), osteopathic physician (DO), advanced registered nurse practitioner (ARNP), or a physician's assistant (PA), may sign).

Note: An ARNP or PA working for a physician licensed under the authority of Sections 458 or 459, FS may sign the medical statement. *The name of the licensed physician MUST also be noted on this statement in addition to the signature of the ARNP or PA, however, the licensed physician's signature is not required*.

_____

Name of Physician (please print)

_____

Physician's Signature

_____

Address

_____

Phone

_____

ARNP's/PA's Signature

_____

Date of Signature