



Part 1 of 3: Physician Verification Form

Student Name:

Date of Birth:

Physician Information (Name, Email, Phone):

The treating practitioner for the diagnosis related to absences should complete this form. Staff will contact the practitioner with follow up questions. It MUST be completed by the treating physician, psychiatrist, nurse practitioner, or licensed mental health practitioner.

1. Please indicate the student's diagnosis.

2. How will the physical and/or psychiatric condition significantly limit the student's ability to regularly attend school?

3. At what time(s) will the student be confined to home or hospital (including frequency and duration of expected absences from school)?

4. Describe the student's treatment plan (including frequency and duration)?

** Excused absence in this context refers to a medically excused absence related to the specific condition: see Parent/Guardian Agreement*

PRIVACY: In accordance with the Family Educational rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) LEARN DC ensures that education records, including health records, are not released to third parties outside of emergency circumstances or consent from the parent/guardian. This form will only be accessed by staff either directly involved in deciding about a student's placement or directly involved in administering education services to the student. This form may be shared with school nurses, physicians, and health care providers for treatment purposes only. If there is an emergency threatening the student's safety this information may only be shared with individuals whose knowledge of these records will assist in protecting the student or others from the threat.



5. List all prescribed medication(s) the student is taking, the side effects of each, and the impact of the medication(s) on the student's ability to achieve educational benefit in the school setting.

Physician's Certification: I certify that this student is under my care and treatment for the aforementioned illness. My recommendation has been made on the medical needs of the patient. This certifies that this treatment plan is medically necessary.

(Print) Physician's Name

Physician's Signature

Date

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Part 2 of 3: Parent/Guardian Agreement

If my student is approved for home/hospital instruction (HHI), I understand and agree to the following (initial each term below):

_____ I will provide a safe, quiet setting for the student and the teacher in my home. This includes securing all animals in another location, refraining from smoking, and minimizing distractions (television off, etc.). If instruction is to occur virtually, I will provide a quiet setting free of distractions and ambient noise, and will communicate with my school regarding any necessary technology required to ensure consistent internet access and virtual participation.

_____ I, or another responsible adult, will be present with the student and teacher at all times.

_____ I will communicate openly and respectfully with the home/hospital instructor and related staff.

_____ I will update all forms upon any change in my student's physician, condition, or treatment plan.

_____ I give permission for the physician(s) and appropriate school personnel to exchange information and records regarding my child's medical condition and instructional program.

_____ I agree to abide by the ITDS Family Handbook policies.

_____ I am aware that not all topics and content areas are available through HHI.

If the student will have intermittent or episodic absences:

_____ I understand that HHI will only be provided for excused medical absences related to the specific medical condition set forth in this application. For an absence to be excused, I understand that I must email _____ by 8:30AM on the day of the absence. If my student has an IEP or 504 plan, I must also include _____.

_____ I understand that HHI will not take place on the day my student is absent, unless absences have been planned and scheduled at least three weeks in advance. HHI for unexpected, periodic, or episodic absences will take place within two weeks of the excused absence date.

(Print) Parent/Guardian's Name

Signature

Date

** Excused absence in this context refers to a medically excused absence related to the specific condition: see Parent/Guardian Agreement*

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