Office Use Only
Start Date:
End Date:
Return to School:

GARRETT COUNTY PUBLIC SCHOOLS
MEDICAL PROFESSIONAL'S RECOMMENDATION FOR HOME & HOSPITAL TEACHING

PARENT/LEGAL GUARDIAN

Date: __________ Student: ____________________________ Sex: ☐M ☐F Date of Birth: ______________________

Address: ____
(Street) (City) (State) (Zip)

School: ______________________________________ Grade: ______________________________

Name of Parent(s)/Guardian(s): ____

Does the student have a current IEP or 504 Plan?: ☐Yes ☐No

Home Phone: _________________ Work Phone(s): ______________________ Other Phone: _________________

E-Mail: ____

I am applying for Home & Hospital Teaching for my child. I grant permission for the Garrett County Board of Education Pupil Services staff to contact and confer with the referring and treating Medical Professional(s) to exchange information about my child. Failure to sign this release of information may result in denial of Home & Hospital Teaching Services

Parent or Guardian Signature: ____

PLEASE PRINT NAME: ____

MEDICAL PROFESSIONAL

PHYSICIAN, PSYCHIATRIST, LICENSED CLINICAL PSYCHOLOGIST OR CERTIFIED SCHOOL PSYCHOLOGIST STATEMENT FOR HOME & HOSPITAL TEACHING

Description of Presenting Problem: ____

Reason student cannot function in the regular school environment: ______________________________
____

Date of Last Appointment: ____________________ Frequency of Appointments: ________________________

Is the student contagious?: ☐Yes ☐No Specify: ____

Are there any precautions needed when teaching this student?: ____________________________
____

Please seriously consider any in-school accommodations that could be made to allow attendance at the home school before making the recommendation for Home & Hospital Teaching.

Home/Hospital Teaching: Approximate Length of Time (60-Day Max.): ____________________
☐ Full Time Home Teaching
☐ Part Time Home Teaching/Part Time School Attendance
(Specify hours to be spent in school each day) ____________

Plan for Return to School: ____

Treating Medical Professional's Name: ______________________________ Phone: ____________________
(Please Print) Fax: ____________________

Signature: ______________________________________ Date: ________________________

☐ Physician ☐ Certified Nurse Practitioner ☐ Psychiatrist ☐ Licensed Clinical Psychologist ☐ Certified School Psychologist

COMPLETE A TREATMENT PLAN (REVERSE SIDE) FOR EMOTIONAL/BEHAVIORAL REFERRALS.

Return completed form to Pupil Services, attention Lindsey Strubin, via FAX at 301-334-7642 or lindsey.gregory@garrettcountyschools.org

Approved By: ______________________________________ Date: ______________________________

GARRETT COUNTY PUBLIC SCHOOLS
TREATMENT PLAN
FOR EMOTIONAL/BEHAVIORAL REFERRALS

Name of Student: ____ Date of Birth: ____________________

To be completed by treating medical professional. Please respond to each question.

1. Diagnosis: ____

2. Is the student seen on regularly scheduled visits to your office: ☐ Yes ☐ No

   Frequency of Visits: ___________________________ Date of Last Visit: _____________________

3. Is the student currently in therapy? ☐ Yes ☐ No

   Therapist's Name: _______________________________ Phone: _______________________________
   Frequency of Visits: ______________________________ Date of Last Visit: _____________________

4. Is the student on Medication? ☐ Yes ☐ No

   Medication(s): ___________________________________ Dosage: ____________________________

   How will the medication(s) affect school performance? ____

5. Describe your treatment plan and how it addresses the student's emotional condition. Please feel free to attach additional information as needed.

   ____
   ____

6. Is Home & Hospital Teaching the preferred academic placement? If so, why?

   ____
   ____

7. Are they any modifications or accommodations that could be made by the home school that would allow the student to return to/remain in the home school?

   ____
   ____

8. What is the plan to transition the student back to school?

   ____
   ____

9. What is the anticipated date of return to school? ______________________________

Treating Medical Professional's Name: ____
(Please print)

Address: ____

Phone: ____ Fax: ______________________________________

Signature: ____ **Date**: ___________________________

☐ Psychiatrist ☐ Licensed Clinical Psychologist ☐ Certified School Psychologist

Reviewed and recommended
by GCBOE School Psychologist: ____________________________ Signature: ___________________________