Kent County Public School Authorization for Home/Hospital Teaching

Instructions to Parent/Guardian: This form is used by Student Services to obtain a certifying professional's recommendation and parent's/guardian's permission to initiate instruction as appropriate. Completed form is maintained in the Office of Student Services. Please complete your portion of this form and have the certifying professional complete his/her portion**. For physical conditions, the certifying professional must be a licensed physician or nurse practitioner. For emotional conditions, the certifying professional must be a certified school or licensed psychologist or a licensed psychiatrist (COMAR 13A.03.05.04). Chronic Conditions are only required to be authorized once a year.**
Once both sections are complete, please give to your child's school counselor as soon as possible.

TO BE COMPLETED BY PARENT/GUARDIAN*:*

Student Name:	Gender:
DOB:	Grade:
School:	Last date of school attendance:
Parent/Guardian:	Address:
Home Phone:	
Work Phone:	Cell Phone:
Does student have current IEP or 504? (Please circle.)	
Name of Treating Professional:	
Address of Treating Professional:	
Phone of Treating Professional:	

I authorize KCPS Supervisor of Student Services or Pupil Personnel Worker to consult with the physician attending my child to confirm the diagnosis and/or clarify the medical notations. I am aware the KCPS has the right to withhold service until the Supervisor of Student Services or the Pupil Personnel Worker has confirmed the need for home/hospital teaching.

Parent Signature: _____ Date: _____

TO BE COMPLETED BY CERTIFYING PROFESSIONAL:

This is to certify that the above-named student was examined by me on / /
Is home/hospital teaching recommended? □ Yes □ No
If yes, Diagnosis:

□ Chronic Health Conditions- Students experiencing chronic conditions leading to continuous absences. It may also be used for students experiencing chronic conditions leading to intermittent absences. Examples are, but not limited to: cancer, depression, bi-polar disorder, cystic fibrosis, etc.
□ Emotional □ Medical
Is the student contagious? □ Yes □ No
If yes, list of precautions to be taken to minimize risk of transmission of disease:

Full Time □ Part Time □ Please Explain:

Estimate of time home/hospital teaching will be required:
Will you continue treatment of student during time he/she is out of school? □ Yes □ No

Signature: _____ Date: _____

Printed Name: _____

Telephone: _____

Professional reverification for need of service is required after **60 calendar days** from date of signature (COMAR 13A.03.05.04)

Revised 3/29/2022