

Medical Certification – Remote Instruction
COVID – 19

This form must be completed and returned to the local school district **before** services can be initiated.

The Illinois State Board of Education (ISBE) has indicated that Home/Hospital Instruction (to include remote instruction) is the most restrictive educational and social environment in which a student may be placed. Students receiving Home/Hospital Instruction will not have physical contact with their peers during the school day. Accordingly, the goal of Home/Hospital Instruction is to “afford the student experiences equivalent to those afforded to other students at the same grade level and are designed to enable the student to return to the classroom.”

In order to establish eligibility for home or hospital services, a student’s parent/guardian must submit to the child’s school district of residence this written statement from a licensed medical physician.

Student’s Name: (Last, Middle, First) PLEASE PRINT		Student’s Address:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Grade Level:	Phone Number:
			School District:
Parent/Guardians’ Name(s): (Last, First) PLEASE PRINT			

Does the student have a current IEP? Yes No

Does the student have a 504 Plan? Yes No

Is the student an English Language Learner? Yes No

Section 1 – THIS SECTION TO BE COMPLETED BY LICENSED MEDICAL PHYSICIAN

Illinois Rules & Regulations for Special Education for Home/Hospital Instruction state that the student will or is anticipated to, due to the student’s medical condition, be out of school for a minimum of one consecutive weeks of school (5 days) or more or on an “ongoing intermittent basis.” (An “ongoing intermittent basis” is defined as that the student’s medical condition is of such a nature or severity that it is anticipated that the student will be absent from school due to the medical condition for periods of at least two days at a time, multiple times during the school year totaling at least ten days or more of absences.)

Medical Diagnosis of physical or mental health condition– please include approximate date condition commenced and probable duration

Date of Last Appointment: _____ **Frequency of Appointments:** _____

Signature of Medical Professional: _____

Is the request for Home/Hospital Instruction being made because of COVID-19? Yes No

If you answered yes to the above question, please identify the barriers COVID-19 has on the student’s ability to attend in-person instruction: *The District is complying with ISBE/IDPH and CDC recommendations for return to school to include: mandatory face coverings, hand washing, frequent cleaning, etc.*

Is the student quarantined because of exposure or possible exposure to COVID-19? Yes No

If you answered yes to the above, please provide the anticipated return date (A release to return to school will be required): _____

Is the request for home instruction for reasons other than COVID-19? Yes No

If you answered yes to the above question, please identify the barriers preventing student from attending in person instruction, including part day: _____

In addition to protocols recommended by the ISBE, IDPH and CDC, are there other in-school accommodations or modifications, including partial day attendance that could be made to allow attendance at the home school before making the recommendation for home instruction?

I recommend home/hospital instruction: Yes No

Full time home instruction (*student will NOT attend school, but can participate in remote instruction*)

Part-time home instruction (*student will attend school part-time*)

Intermittent home instruction (*short-term home instruction for a specific time period*)

Illinois requires a minimum of 5 hours per week of home instruction. If the student cannot tolerate that amount of instruction due to his/her medical condition, **please indicate how many hours of instruction per week the student should receive:** _____

Estimated date when student will no longer need home/hospital services (*Please note that the terms lifetime, unknown, or indeterminate do not meet state requirements. If the student's condition requiring removal from the classroom will continue indefinitely, the IEP team should discuss all placement options available.*)

Date: _____

List prescribed medication(s) and any side effects relevant to academic instruction:

List any special recommendations to the teacher regarding the treatment plan and how it will affect academic instruction:

To the extent possible, home instruction will be provided remotely. **When remote instruction is not possible, can in-home instruction be provided:** Yes No

If yes, identify any accommodations required, other than ISBE, IDPH or CDC recommendations, to be followed in the home environment:

Plan for return to school (*including medical needs/accommodations necessary for the student to return to school*):

Anticipated return date: _____

Section 2 – THIS SECTION FOR SCHOOL DISTRICT USE

Student qualifies for remote instruction? Yes _____ No _____

Explanation (lack of documentation, indefinite return, alternative placement made):

Date of request: _____

Original Request

Extension

Beginning date of remote instruction: _____

Beginning date of extension: _____

(Beginning date on extension must consecutively follow end date of original.)

Date request received: _____

IEP/504 Team Meeting date, if applicable: _____