JORDAN PUBLIC SCHOOLS

Please return form to:
Jordan Public Schools
Attn: Chad Williams
500 Sunset Drive, Suite #1
Jordan, MN 55352

Phone: 952-492-4230
Fax: 952-492-4445
cwilliams@isd717.org

MEDICAL APPLICATION FOR HOMEBOUND INSTRUCTION

I give consent to the healthcare provider to share medical information regarding my son/daughter for the purpose of setting up Homebound Instruction.

Parent or Guardian's Signature:_____ Date:_____

Student Name:_____ School:_____

Birth Date:_____ Grade:_____

Address:_____ City:_____ Zip:_____

Phone (home):_____ Phone (work):_____

Health Care Provider: Homebound Instruction **can only be provided** when a medical authority provides written verification of the students' **confinement** to the students home and is unable to participate and restricted to any other activity outside the home. (If the student can attend part-time please specify amount of time.) Please respond to all of the applicable questions that follow:

1. Diagnosis/Condition:_____
2. Anticipated Hospital Release Date:_____
3. Anticipated Date of Return to School:_____
4. Should Return to school full days: Yes_____ No_____
   In NO, what should the length of the day be and for how long should the student attend partial days?_____
5. Pregnancy: Estimated Delivery Date:_____
6. If the student will miss school intermittently due to a health condition, please describe when the student would be unable to attend school:_____
   _____
7. Information school health staff need for the student's return to school:_____
   _____

Frequently we need additional information about a student; therefore, it is essential that all of the information about the health care provider be complete and legible.

Health Care Provider's Signature:_____
Provicer's Address and Zip Code:_____

Print Name of Above Signature:_____
Provider's Telephone Number:_____
Consent automatically expires 1 year from the date this form is signed.

Expiration date _____