MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
SPECIAL EDUCATION-COMPLIANCE

HOMEBOUND INSTRUCTION – Documentation Form (Revised 2016)

District Use Only
Start Date: _____
End Date: _____
Return to School: _____

I. STUDENT INFORMATION

Date of Application: ☐ Initial ☐ Extension (Circle One) 1 2 3

Type of Application: ☐ Medical ☐ Reevaluation ☐ Suspension/Expulsion ☐ Other:

Name of Student: DOB: Grade:

Name of Parent/Guardian: Phone Number:

Home Address:

II. SCHOOL DISTRICT INFORMATION

1. Teaching completed by: ☐ Phone ☐ Home teaching ☐ Other:

2. Estimated total length of homebound services:

Name of Teacher		Area(s) of Certification	
Legal Name of Educational Agency Nixa Public Schools	District Contact Person\ Karen McKnight	Telephone 417-449-3270	Fax 417-449-3273
Address 301 S. Main St.	City Nixa	State MO	Zip Code 65714

III. EDUCATIONAL INFORMATION (To be completed by Director/Coordinator of Special Services)

1. Does the student have an IEP? ☐ Yes ☐ No

2. Are you requesting a reevaluation? ☐ Yes ☐ No (If yes, enclose copy of Notice of Reevaluation)

3. Has the IEP Team met? ☐ Yes ☐ No (If yes, date: _____)

4. Has this student been suspended or expelled? ☐ Yes ☐ No (If yes, enclose copy of Change of Placement and Manifestation Determination)

5. Is this student not attending due to a court injunction? ☐ Yes ☐ No (If yes, attach copy of court order)

IV. MEDICAL INFORMATION (To be completed by Physician)

Homebound services are reserved for those enrolled students who must temporarily be confined at home or in a health care facility. Homebound services are generally not appropriate for students who are able to maintain a work schedule.

1. Does condition prevent student from maintaining school and work schedule? ☐ Yes ☐ No

2. Medical or Psychological Diagnosis:
If pregnant, please indicate due date.

3. Number of weeks student will require homebound: Date of appt/hospitalization: Homebound start date:

4. Recommendations and explanations of diagnosis:
(NOTE: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into regular school environment as soon as possible. **Please attach plan for re-entry**.)

Signature of Physician	Date	Print Physician's Name	
Address of Physician	State	Zip	Phone

Indicate Area of Licensed Specialty: ☐ M.D. ☐ D.O. ☐ Psychiatrist ☐ Psychologist

V. CERTIFICATION (To be completed by the School District)

I certify that a need for homebound service exists & provision of homebound instruction is the most appropriate educational alternative at this time.

Superintendent or Authorized Representative	County/ District Code 022-089	Date

MEDICAL PERSONNEL
Mail or fax form to the school district where the child is enrolled.
NOTE: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into regular school environment as soon as possible

Building Principal
I have consulted with appropriate staff and determined that the student meets the criteria for homebound instruction as outlined in Board policy and recommend that homebound services be provided.
Signature: _____ **Date:** _____