OFFICE USE ONLY

Start Date:

End Date:

Return to School:

Medical Professional's Recommendation for Home & Hospital Services for EMOTIONAL/BEHAVIORAL Health Conditions

PARENT/LEGAL GUARDIAN

Date: _____ Student: _____ Sex: ◯ M ◯ F Date of Birth: _____

Address: _____
(street) (city) (state) (zip)

School: _____ Grade: _____ Does the student have an IEP/504 Plan? ◯ Y ◯ N

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

Parent Phone Number: _____ Parent Email: _____

I am applying for Home & Hospital Teaching for my child. I grant permission for the GCPS Student 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

PSYCHIATRIST, LICENSED CLINICAL PSYCHOLOGIST, PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER (PMHNP), OR CERTIFIED SCHOOL PSYCHOLOGIST STATEMENT FOR HOME & HOSPITAL

Please describe the emotional condition that prevents the student from attending the regular school program.

_____

***Please seriously consider any in-school accommodations that could allow student to attend school.**

How does the emotional condition prevent the student from attending school? _____

_____

Are there any precautions needed when teaching this student? ☐ Y ☐ N _____

List strategies that have been successful: _____

Date of Last Appointment: _____ Frequency of Appointments: _____

Requested Duration of Services (no more than 60 days): _____

Recommendations for School Attendance:

☐ Full-time: Student is UNABLE to attend school.

☐ Part-time: Student is able to attend school PART-TIME. Describe: _____

☐ Concurrent: Student is eligible for tutoring after CONSECUTIVE ABSENCES due to emotional condition.

☐ Student is able to attend regular school program WITH MODIFICATIONS.

Please list any modifications that would enable the student attend school (i.e. modified setting, etc.):

_____

Please complete page 2 of this form.

Psychiatrist/Psychologist/PMHNP's Signature:: _____ Date: _____

Printed Name: _____ Phone: _____ Fax: _____

* Return completed form to Student Services, attention Lindsey Strubin: FAX: 301-334-7642 or EMAIL: lindsey.strubin@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? ☐ Y ☐ N

3. Is the student currently in therapy? ☐ Y ☐ N

Therapist's Name: _____ Phone Number: _____

Frequency of Visits: _____ Date of Last Visit: _____

4. Is the student on medication? ☐ Y ☐ N

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 there 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: _____