RESET FORM

PGCPS
Office of Home and Hospital Teaching
301-567-8642| home.hospital@pgcps.org
8437 Landover Road|Landover, MD 20785

PHYSICIAN'S VERIFICATION: Physical Conditions

This form is used to obtain the **recommendation** of a licensed physician to initiate Home and Hospital Teaching (HHT) services for students who have a physical condition that renders them **unable** to attend school. Written verification of the condition by a licensed physician/nurse practitioner, and confirmation that the identified student is under the care of the verifying physician, is required to process a request for HHT. School personnel may need to contact the referring physician for additional information necessary to determine eligibility. Services may be denied if the medical person cannot be reached within five days of the initial attempt to make contact. Your signature below provides authorization for the physician to **release information** to PGCPS staff.

Parent Signature: _____ Date: _____

Student Information:

Student Name: _____ Date of Birth: _____

School Name: _____ Student Grade: _____

Student PGCPS ID#: _____

Information for Health Care Provider Consideration:

- In many cases, the school team can work with the family of a student experiencing health challenges to accommodate the student in school.
- The parent/guardian and the school team should discuss accommodations that may be available in some cases.
- This form must be completed by the Health Care Provider treating the student every 60 calendar days.
- Home and Hospital Teaching is not intended to replace school attendance (35 hours of instruction per week).
- Approved students receiving Home and Hospital Teaching receive approximately **6** hours of instruction per week.
- Additional pertinent medical information regarding the student's case may be attached for review.
- Prince George's County Public Schools **does not offer online or virtual school** in lieu of regular school attendance.

Medical Information for Home & Hospital Teaching Determination:

1. **Indicate the diagnosis that will prevent the student from attending school for 20 or more days.**

2. Date HHT services should begin:		Anticipated **duration** of service (**WEEKS ONLY**):
3. Which statement best describes how the student's medical condition impacts the student's participation in school:		◯ Unable to attend school ◯ Able to attend school intermittently as health permits

4. If the student is **UNABLE TO ATTEND SCHOOL**. Describe how the student's medical condition renders the student unable to attend school based on the diagnosis in question #1 (additional information may be attached).

Student Name: Date of Birth:

PHYSICIAN'S VERIFICATION: Physical Conditions (CONTINUED)

5. If the student can **ATTEND INTERMITTENTLY AS HEALTH PERMITS**. Describe how the student's medical condition renders the student able to attend school intermittently as health permits based on the diagnosis in question #1(additional information may be attached).

6. I am the healthcare provider who will be treating and continuing the treatment or supervision of this student.	☐ **NO** ☐**YES**
7. Date of last examination of the above-named student.	
8. Is the student currently taking medication?	☐ **NO** ☐ **YES**
9. Provide the names of the medication and dosage.	

10. Describe the treatment plan for this student:

11. PGCPS does not offer a full-time online instructional program, what accommodations would permit the student to attend school?

For Pregnant Students:
Indicate estimated delivery date:

Health Care Provider Verification:

Health Care Provider's Name and Title (Print):

Health Care Provider: ☐ Licensed Physician ☐ Nurse Practitioner

License Number: Contact Phone Number:

This form is valid for 60 days from the date of the physician's signature.

Signature of Health Care Provider: Date: