



Application for Home and Hospital Teaching

Office of Special Education and Student Services
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland

MCPS Form 311-15
April 2011

Note: This form is used by the Home and Hospital Teaching (HHT) Office to obtain physician's recommendation and parent's permission to initiate instruction for students with medical or emotional problems. Return completed application to school counselor or principal designee. **A new completed application is required for continuation of service beyond 60 calendar days.**

TO BE COMPLETED BY PRINCIPAL DESIGNEE. PLEASE PRINT.

Student Name _____ ID# _____ Sex M F DOB ___/___/___

School _____ Grade _____ Last day of school attendance _____

Home Address _____ City _____ State _____ Zip Code _____

Check Box 504 Plan IEP

Parent/Guardian Telephone Number Home ___-___-___ Work ___-___-___ ext. ___ Cell ___-___-___

Parent/Guardian Name (please print) _____

Date application given to parent ___/___/___ **Date application returned from parent** ___/___/___

Date school submitted application to HHT Office ___/___/___ **Designee Signature** _____

I authorize Montgomery County Public Schools (MCPS) to consult with the physician/psychiatrist/psychologist treating my son/daughter to confirm the diagnosis and/or clarify the medical notations. I am aware MCPS has the right to withhold service until the need for home and hospital teaching service has been confirmed.

Signature of Parent/Guardian _____ Date ___/___/___

TO BE COMPLETED BY PHYSICIAN

This is to certify that the above named student was examined by me on ___/___/___

Is home and hospital teaching recommended? Yes No

I will I will not be responsible for the continuing of treatment or supervision during the time he/she is out of school.

Diagnosis _____ Is this a contagious disease? Yes No

If yes, list the precautions to be taken by staff to minimize risk of transmission of disease. _____

If home and hospital teaching is recommended, reason for recommendation and treatment plan with criteria for return to school.

If pregnant, list expected date of delivery ___/___/___

Estimate of time home and hospital teaching will be required _____

Signature, Physician _____ Date ___/___/___

Address _____ Telephone ___-___-___

Student Name _____ ID# _____

TO BE COMPLETED BY SCHOOL MEDICAL ADVISOR

Recommendation of School Medical Advisor _____

School Medical Advisor name _____ Date ____/____/____

TO BE COMPLETED BY NON-MCPS PSYCHIATRIST/PSYCHOLOGIST AND MCPS SCHOOL PSYCHOLOGIST

Psychiatrist/Psychologist _____ Work Phone ____-____-____

Address _____
Street City State Zip

I will I will not be responsible for the continuing of treatment or supervision during the time he/she is out of school.

A. Is this incidence of emotional distress so acute as to be critical to the child's emotional or physical well-being, taking into consideration the onset of the disorder and the length of time the student will be outside of the public school? Yes No

B. If HHT is recommended, please attach a brief report including the following: 1. Specific diagnosis and prognosis; 2. Medicine and dosage; 3. Reason HHT is recommended; 4. Treatment plan with criteria for return to school.

Signature, Non-MCPS Psychiatrist/Psychologist ____/____/____
Date

Reviewed by the MCPS School Psychologist:

Signature, MCPS Psychologist ____/____/____
Date

Comments _____

TO BE COMPLETED FOR MCPS SCHOOL PSYCHOLOGIST REFERRAL

School Psychologist _____ Telephone ____-____-____

Location _____ Recommended duration of HHT services _____

Comments _____

