BALTIMORE COUNTY PUBLIC SCHOOLS

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COVID-19 School Closure Statement

To All Medical Doctors, Psychiatrists, and Psychologists

The Home and Hospital Program of Baltimore County Public Schools traditionally provides an educational alternative for students who are unable to participate in the comprehensive school's programming due to medical and or emotional needs. Their illness prevents them from attending a full day of regular school programming.

In the wake of the COVID-19 Pandemic, Baltimore County Public Schools is offering remote learning for ALL BCPS students. There will be no face to face instruction for all students until after January 29, 2021. Students will be able to engage in online learning with their classmates and teachers in their regular school community.

The Home and Hospital Program is encouraging families and schools to allow students to begin their initial instruction with their peers and classroom teachers in order to provide access to their school community. If medical and/or emotional conditions are severe or continue to be a barrier to their educational access, students can still be referred to the Home and Hospital Program for online instruction with modifications and reduced time.

We appreciate your cooperation and are here to support and collaborate with you.

The Home and Hospital Program

Baltimore County Public Schools

Date Received by Enrollment School: _____

APPLICATION FOR INSTRUCTIONAL PROGRAM
FOR HOMEBOUND OR HOSPITALIZED STUDENTS
HOME AND HOSPITAL PROGRAM
Baltimore County Public Schools
6229 Falls Road, Baltimore, MD 21209
Telephone 410-887-3222
Email hhreferrals@bcps.org

PROFESSIONAL STATEMENT PHYSICAL/PREGNANCY CONDITION- SY 2020-2021

PLEASE REVIEW THE ATTACHED COVID-19 SCHOOL CLOSURE STATEMENT BEFORE COMPLETING THIS FORM

NOTE: All portions of this professional statement must be completed for Home and Hospital instructional services to be considered. All signatures are required for processing.

Please indicate credentials: ☐ Pediatrician ☐ Obstetrician ☐ Nurse Practitioner ☐ Specialist (Please indicate): _____

(*A Physician Assistant or Midwife may NOT be the sole signature on this Professional Statement. Only a psychiatrist, licensed psychologist, or school psychologist may certify EMOTIONAL conditions using the Emotional Professional Statement*)

Name of Student: _____ Sex: ☐ Male ☐ Female Date of Birth: _____
Address: _____
_____ Zip Code: _____
School: _____ Grade: _____

Doctor's Name (please print): _____
Office Telephone Number: _____ Office Fax Number: _____
Office Address: _____
_____

I. Medical diagnosis/condition:

_____
_____

*Date of Last Examination: _____ For Pregnancy, Due Date: _____
*Is the student seen on regularly scheduled visits to your office? ☐ Yes ☐ No
Frequency of visits: _____ Date of last visit: _____
*Is the student currently on medication? ☐ Yes ☐ No
*If Yes; Medication(s)/Dosage(s) _____
_____
How will the medication(s) affect school performance?_____
_____
_____

*Impact on School Attendance (Description of how the impact precludes the student from attendance at the school of enrollment.)

- ☐ Immune Suppression
- ☐ Fatigue
- ☐ Medically restricted activity; Describe: _____
- ☐ Pain
- ☐ Other; Describe: _____

*Recommended type of program for student:

☐ **Full Time Physical** - (*For a student anticipated to be **continuously** absent for 20 or more school days*)
Must complete Part II

☐ **Full Time Pregnancy -** *(*Students are eligible to receive Home and Hospital instruction one week prior to the anticipated due date and may continue receiving instruction six weeks post-delivery*)*

☐ **Chronic/Intermittent** – SERVICES TO BEGIN WHEN SCHOOLS RE-OPEN FOR IN-PERSON INSTRUCTION *(*For a student anticipated to be **intermittently** absent due to a verified chronic condition throughout the school year*)* ***Do not complete Part II***

II. Full Time Physical Program ONLY –

Anticipated Length of Absence from School: _____ (request must not exceed 60 calendar days)

If more time is required, re-verification of condition is required prior to the expiration date

III. Any restrictions on activity for school program? ☐ Yes ☐ No

*****If yes, please describe the restrictions. _____

_____

_____

IV. Does the student have a contagious condition? ☐ Yes ☐ No

*If yes, please describe the condition and needed precautions for teachers:

_____

_____

NOTE: By signing this statement, I certify that:

- **I am currently treating the above-named student.**
- **This student is not able to attend the regular day-school program with modifications because of his/her medical condition.**
- **I understand that students approved for the full-time Home and Hospital instructional services with a tutor typically receive 6 hours of instruction per week and that these services are the student's sole source of instruction—not a supplemental tutoring service.**
- **I have reviewed the COVID-19 statement**

MD/NP Signature: _____ Date: _____

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As the parent/guardian of the above student, I give my permission for my son/daughter to be referred to the Home and Hospital Program and when necessary, for the administrator, or his/her designee, to contact the physician above in reference to the medical condition(s) necessitating this referral. I am aware additional medical information may be required, as needed.

Signature of Parent/Guardian: _____ **Date:** _____

E-mail Address: _____

Phone Numbers: (H) _____ **(W)** _____ **(C)** _____

For Home and Hospital Use Only

Date Received:_____

Date Assigned:_____

Rev. 07/2020