Roosevelt School District #66

District Office
6000 S. 7th Street, Phoenix, AZ 85042
Phone: (602) 243-4832 FAX: [602] 304-3114

MEDICAL CERTIFICATION FOR HOMEBOUND SERVICES/CHRONIC ILLNESS

School: _____

Student's Name: _____ Date: _____
Date of Birth: _____ Student ID#: _____ Grade: _____
Parent/Guardian: _____ Home Phone: _____
Home address: _____ Other Phone: _____

Arizona Statute regarding Homebound Services: § A.R.S. 15-901 (B) (14)

"Homebound" or "hospitalized" means a pupil who is capable of profiting from academic instruction but is unable to attend school due to illness, disease, accident or other health conditions, who has been examined by a competent medical doctor and who is certified by that doctor as being unable to attend regular classes for a period of not less than three school months or a pupil who is capable of profiting from academic instruction but is unable to attend school regularly due to chronic or acute health problems, who has been examined by a competent medical doctor and who is certified by that doctor as being unable to attend regular classes for intermittent periods of time totaling three school months during a school year. The medical certification shall state the general medical condition, such as illness, disease or chronic health condition that is the reason that the pupil is unable to attend school. Homebound or hospitalized includes a student who is unable to attend school for a period of less than three months due to a pregnancy if a competent medical doctor, after an examination, certifies that the student is unable to attend regular classes due to risk to the pregnancy or to the student's health.

PHYSICIAN'S STATEMENT:

The medical certification shall state the general medical condition, such as an illness, disease, or chronic health condition, that is the reason the student is unable to attend school.

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□ I hereby certify this student as being unable to attend regular classes for a period of not less than three (3) school months or for intermittent periods of time totaling three (3) school months during a school year.

□ I request this student be provided with assistance since a chronic illness will cause him/her to be absent frequently during the school year. I do not anticipate these absences will total three (3) school months.

Physician's Signature: _____ Date: _____
Physician's Name: _____ Physician's Telephone Number: _____
Physician's Address: _____

For Office Use Only:
Date Received: _____ Date Approved: _____
Homebound Teacher Providing Instruction: _____
Date Services Begin: _____ Date Services End: _____

02/2016 jc