SUWANNEE COUNTY SCHOOL BOARD
WORKSHOP SESSION
July 11, 2023

AGENDA

9:00 a.m. Call to Order/Welcome/Pledge ..... Jerry Taylor, Chairman

9:02 a.m. Suwannee Education Foundation Update ..... Lori Evans

9:30 a.m. Student Services Department Update ..... Kelly Waters/ Elizabeth Johnston

- Various Forms **(pgs. 2-11)**

10:00 a.m. Superintendent Update ..... Ted Roush

10:30 a.m. Adjourn

# SUWANNEE COUNTY SCHOOL BOARD

*Office of Student Services*

*1740 Ohio Avenue, South Live Oak, Florida 32064*

## Physician's Statement

The Suwannee County School Board seeks information from you for the purpose of education planning. The student has been referred by his/her teacher/parent due to difficulties in school. Please complete the sections below to assist us in providing appropriate educational services for this student.

**Individuals able to complete this form:**

- **A Physician licensed in Florida** in accordance with Chapter 458 or 459, F.S., unless a report of medical examination from a physician licensed in another state is permitted in accordance with paragraph 6A-6.0331(3)(e), F.A.C..
- If completed by a licensed **ARNP or PA**, per state board rule, **the name of a licensed supervising physician must be noted on this form.**

**School:** _____ **School Contact:** _____

**School Address:** _____ **Phone:** _____

_____ **Fax #:** _____

***Upon completing the form, return to the Fax# above.***

**Student Name:** _____ **Date of Birth:** _____ **Grade:** _____

**1) What is the student's medical diagnosis?** *(Please include a description of the impairment)*

**2) I have prescribed the following medication(s) to treat symptoms of this medical condition:**

**3) Date of last physical examination:**

**4) Date of last hearing screening and results:** *(Pass, Fail, Functional)*

**5) Date of last vision screening and results:** *(Pass, Fail, Functional)*

**6) How might the diagnosis(es) impact the student's learning in the educational environment?**

| | | |
|---|---|---|
| ☐ Difficulty Following Directions | ☐ Frequent Absences | ☐ Limited Alertness/Attention |
| ☐ Disorganized | ☐ Heightened Alertness | ☐ Limited Concentration |
| ☐ Distractible | ☐ Hyperactive | ☐ Limited Strength |
| ☐ Easily Frustrated | ☐ Hypoactive | ☐ Tires Easily |
| ☐ Focus | ☐ Impulsive/Excitable | |

☐ Limited Ability to Move, Sit, or Manipulate Materials in the Learning Environment.

☐ Other: _____

**PHYSICIAN CERTIFICATION** *(State of Florida License Information)*

Physician's Name_____ License # _____ Phone# _____

Office Name _____ Address _____

Fax # _____ Email _____

**ARNP or PA CERTIFICATION** *(State of Florida License Information)*

ARNP/PA's Name_____ License # _____ Phone# _____

Office Name _____ Address _____

Fax # _____ Email _____

Name of Licensed Physician Surpervising of ARNP/PA ***(must be listed)***_____

Revised Form

# SUWANNEE COUNTY SCHOOL DISTRICT

*Office of Student Services* *Revised District to Board*

*1740 Ohio Avenue, South Live Oak, Florida 32064*

## *Revised District to Board* Physician's Statement

The Suwannee County School District seeks information from you for the purpose of education planning. The student has been referred by his/her teacher/parent due to difficulties in school. Please complete the sections below to assist us in determining eligibility and in providing appropriate educational services for this student. Please complete the form, sign, and return to the address or fax number below. This form must be signed by a **Medical Doctor**. **Revised the wording in this section**

**School:** _____ **School Contact:** _____

**School Address:** _____ **Phone:** _____

_____ **Fax #:** _____

**Student Name:** _____ **Date of Birth:** _____ **Grade:** _____

**1) What is the student's medical diagnosis?** *(Please include a description of the impairment)*

**2) I have prescribed the following medication(s) to treat symptoms of this medical condition:**

**3) Date of last physical examination:**

**Added Hearing & Vision Screening to this section**

**4) How might the diagnosis(es) impact the student's learning in the educational environment?**

- ☐ Difficulty Following Directions
- ☐ Disorganized
- ☐ Distractible
- ☐ Easily Frustrated
- ☐ Focus
- ☐ Frequent Absences
- ☐ Heightened Alertness
- ☐ Hyperactive
- ☐ Hypoactive
- ☐ Impulsive/Excitable
- ☐ Limited Alertness/Attention
- ☐ Limited Concentration
- ☐ Limited Strength
- ☐ Tires Easily
- ☐ Limited Ability to Move, Sit, or Manipulate Materials in the Learning Environment.
- ☐ Other: _____

Old form

**Physician's Printed Name:** _____ **Date Signed:** _____

**Physician's Signature:** _____ **Office Number:** _____

**Physician's Mailing Address:** **Revised this section**

# Exceptional Student Education

## Student Services Office




# Hospital/Homebound Program

1740 Ohio Avenue South
Live Oak, FL 32064
(386) 647-4630
(386) 208-8687-Fax

# SUWANNEE COUNTY SCHOOL BOARD

EXCEPTIONAL STUDENT EDUCATION

## Hospital Homebound Request
## Parent/Guardian Consent

**Definition:** A homebound or hospitalized student is a student who has a medically diagnosed physical or psychiatric condition that is acute or catastrophic in nature, a chronic illness, or a repeated intermittent illness due to a persisting medical problem and which confines the student to home or hospital and restricts activities for an extended period of time. *(Rule 6A-6.0320, F.A.C.)*

**Purpose:** Hospital Homebound services are limited and basic in nature. Our goals are to minimize instructional gaps by providing temporary access to academic curriculum while the student is medically confined and to promote reentry into a traditional school setting.

**Instructions:** The student listed below is being considered for Hospital Homebound Instructional Services based on a severe medical diagnosis confining the student to the home/hospital. Provide details regarding the medical diagnosis to assist us in making appropriate educational decisions. Return the completed form to SCSD's Student Services Office in the District Office. For questions, contact Student Services at (386)-647-4630.

**Section I: Student Information and Release of Information** *(to be completed by parent/guardian)*

| Student ID # | Student First Name | MI | Last Name | Date of Request |
|---|---|---|---|---|
| | | | | |

| Birth Date | Grade | Current School |
|---|---|---|
| | | |

| Parent/Guardian Name | Parent/Guardian Email Address |
|---|---|
| | |

| Address |
|---|
| |

| City | State | Zip Code | Parent/Guardian Preferred Phone # | Alternate Phone # |
|---|---|---|---|---|
| | | | | |

**RELEASE OF INFORMATION**

*I hereby authorize the student's physician(s) to release all information concerning diagnoses, treatment plan, medical implications for instruction, and reentry plan to Suwannee County School Board. This communication may be written or verbal. This release will remain in effect until the student has been dismissed/discontinued from Hospital Homebound services.*

_____ _____

*Parent/Guardian/Student at the Age of Majority Signature* *Date*

**Section II: Physician Contact Information** *(to be completed by parent/guardian)*

***Listed below are the rules for the medical professional able to complete the medical statement to be considered for Hospital Homebound Instruction.***

- A physician licensed in Florida in accordance with Chapter 458 or 459, F.S.
- An advanced registered nurse practitioner (ARNP) or Physician's Assistant (PA) working for a physician licensed under the authority of Sections 458 or 459, F.S., may sign the medical statement instead of the physician. The name of the licensed physician must be noted on the statement in addition to the signature.
- A report of medical examination from a physical licensed in another state is permitted in accordance with paragraph 6A-6.0331 (3)(e), F.A.C.

| Physician/ARNP/PA's Name | Physician/ARNP/PA's Business Name |
|---|---|
| | |

| Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Email Address | Phone # | Fax # |
|---|---|---|
| | | |

**Section III: District Physician/ARNP/PA Verification** *(to be completed by SCSD's Student Services Office)*

| Physician/ARNP/PA's License Number | Physician/ARNP/PA's Licensing State | Physician/ARNP/PA's Area of Practice | ARNP/PA Physician's Name: |
|---|---|---|---|
| | | | |

_____

*Signature of Person Verifying Information (SCSD) & Date*

# Suwannee County School Board

## Hospital Homebound Request

1740 Ohio Avenue South Live Oak, FL 32064
Phone 386-647-4630 or FAX 386-208-8687

## Parent or Guardian Section

**Student Name**_____ **DOB**_____
Last First MI *(PLEASE PRINT)*

**Address**_____
Street City Zip

**Parent/Guardian(s) Name**_____

**Phone: Home**_____ **Cell** _____ **Email**_____

**Current School**_____ **Grade** _____

**Home Room Teacher**_____ **Do you have a home computer? Y N**

**Last day student was in the classroom on a regular basis** _____

### Eligibility Policies

1. I understand that eligibility is based on Florida Statutes, State Board Rule 6A-6.03020, and that the physician statement and medical referral forms are part of the information used to determine eligibility;
2. I understand that my child must be enrolled in a public school prior to the submission of the referral for Hospital/Homebound services;
3. I understand that Hospital/Homebound services are for students confined to the home or hospital due to a medical or mental condition, which is acute, catastrophic, or chronic in nature;
4. I understand that my child will be dismissed from the Hospital/Homebound services program and returned to school once my child is no longer eligible for Hospital/Homebound services.

### Program Dismissal

**Dismissal from the Hospital Homebound Program may occur for the following reasons:**

1. The physician recommends the student can attend his/her district assigned school;
2. The student is unable to participate in and benefit from instruction;
3. When Suwannee County School District's Student Services Office does not receive an updated Physician's Certification form by the expiration date, the student will be withdrawn to his/her assigned school.

_____
*Parent/Guardian Signature & Date*

# Suwannee County School Board

## Hospital Homebound Request

1740 Ohio Avenue South Live Oak, FL 32064
Phone 386-647-4630 or FAX 386-208-8687

# PARENT/GUARDIAN AGREEMENT

**If approved, I understand the following:**

- ☐ I will provide a quiet, clean, well-ventilated setting for student and teacher in my home;
- ☐ I will ensure that a responsible adult is present;
- ☐ I will establish a schedule for student study between delivered instructional times;
- ☐ I will foster my child's independent work ethic and will assist only as needed;
- ☐ I will provide Hospital/Homebound an updated medical application prior to expiration date;
- ☐ If there is a change in physician, I will provide an additional Hospital/Homebound application, completed by the new physician;
- ☐ I agree to provide the Hospital/Homebound program staff any updated information regarding the physician's treatment plan for my child;
- ☐ I give permission for the physician(s) and appropriate school board personnel to exchange information and records regarding my child's medical condition, diagnosis and instructional program; ***Parent/Guardian ( ) initials***
- ☐ I agree to cooperate with the SCSD policies including the Code of Student Conduct and those of the Hospital/Homebound Program, during my child's enrollment in the Hospital/Homebound Program;
- ☐ I am aware that AP courses and some electives courses are not available through the Hospital/Homebound program;
- ☐ Upon withdrawal from the Hospital/Homebound program, I understand that I must enroll my child back in his/her district school;
- ☐ I understand that provision of incomplete information may delay the application and eligibility determination process to the Hospital/Homebound Program.

_____ _____

Parent/Guardian Signature Date

**(NOTE:** *Provision of incomplete information below may delay application process)*

# Suwannee County School District

## Hospital Homebound Request

1740 Ohio Avenue South Live Oak, FL 32064
Phone 386-647-4630 or FAX 386-208-8687

## Medical Information & Certification

*(to be completed by the treating physician)*

- Information must be printed.
- A Physician licensed in Florida in accordance with Chapter 458 or 459, F.S., unless a report of medical examination from a physical licensed in another state as permitted in accordance with paragraph 6A-6.0331(3)(e), F.A.C., must certify medical information.
- If completed by a licensed ARNP or PA, per state board rule, the name of a licensed supervising physician **must be noted on this form.**

**PHYSICIAN CERTIFICATION** *(State of Florida License Information)*

Physician's Name_____ License # _____

Office Name _____ Address _____

Phone# _____ Fax # _____ Email _____

**ARNP or PA CERTIFICATION** *(State of Florida License Information)*

ARNP/PA's Name_____ License # _____

Office Name _____ Address _____

Phone# _____ Fax # _____ Email _____

Name of Licensed Physician Surpervising ARNP/PA _____

**MEDICAL CERTIFICATION:** The above licensed physician or ARNP/PA must certify the following statements.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature? |
| ☐ | ☐ | Is the student not able to attend regular school and be *CONFINED to the home or hospital during the time Hospital Homebound services are expected? *(*in regards to being able to attend school)* |
| ☐ | ☐ | Is the student able to receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact? |
| ☐ | ☐ | Is the student expected to be absent from school due to a medical condition for at least fifteen (15) consecutive days? _____*(# of estimoted expected absences)* |
| ☐ | ☐ | Is the student expected to be absent from school due to a chronic medical condition for at least fifteen (15) nonconsecutive days? |
| ☐ | ☐ | Is the student confined to the home or hospital (facility)? |

_____ _____ _____

**Physician/ARNP/PA Signature** **Print Name of Physician/ARNP/PA** **Date**

*(must be original, stamps are not accepted)*

# Suwannee County School Board

## Hospital Homebound Request

1740 Ohio Avenue South Live Oak, FL 32064
Phone 386-647-4630 or FAX 386-208-8687

## PHYSICIAN TREATMENT PLAN

FLORIDA STATE BOARD RULE 6A-6.03020 **REQUIRES *THE FLORIDA LICENSED*** PHYSICIAN(S) or other TO DESCRIBE THE **PLAN OF TREATMENT AND PROVIDE RECOMMENDATIONS FOR SCHOOL RE-ENTRY.**

PLEASE COMPLETE THE FOLLOWING:

1. Please indicate the student's medical diagnosis/ description of the disabling condition and the associated medical implications for instruction. Include an explanation of how the dianosis/disabling condition prohibits the student from attending school.

2. Explain in detail how the physical or psychiatric condition you have diagnosed will significantly limit the child's ability to receive educational benefit in the regular school setting. In what way(s) would the child's ability to function in the school setting be jeopardized?

3. Describe your treatment plan including current therapies/treatments. Include the frequency and duration of the treatment for psychiatric or medical condition.

4. List any medication(s) the child is taking and explain the effects, if any, the medication(s) may have on the child's ability to achieve educational benefit?

5. The Hospital/Homebound Program is designed to be a **temporary** educational program to help children who are unable to attend school for medical or psychiatric reasons. The amount of instruction provided by the Hospital/Homebound Program is **significantly** less than that provided by the regular school setting. Given this, indicate below the date this student will reenter his/her district assigned school:

**RE-ENTRY DATE:** _____

(**NOTE:** *Provision of incomplete information below may delay application process)*

**Physician's Certification**: I certify that this student is under my care and treatment for the aforementioned illness. My recommendation has been made on the medical needs of the patient, keeping in mind that the least restrictive setting is mandated by federal law.

**This certifies that this treatment plan is medically necessary. Date:** _____

_____ _____

**(Print) Physician's Name** **Physician's Signature**

(If an ARNP or PA signs above, the name/phone number of the supervising physician is required below.)

_____ _____

***Supervising Physician Name*** ***Supervising Physician Phone***

# Suwannee County School Board

## Hospital Homebound Request

1740 Ohio Avenue South Live Oak, FL 32064
Phone 386-647-4630 or FAX 386-208-8687

# PRINCIPAL or SCHOOL DESIGNEE AGREEMENT SECTION

**The Hospital/ Homebound staff forms a partnership with the student's assigned school in order to facilitate and support the delivery of educational services. THE PUBLIC SCHOOL WHERE THE STUDENT IS CURRENTLY ENROLLED WILL:**

- Provide assignments, grades and maintain the record of attendance until the student is officially enrolled in the Hospital/Homebound program;
- Provide withdrawal grades and student schedule(s) to the Hospital/Homebound program, upon request;
- Provide applicable textbooks and work for the student;
- Participate as a member of the Individual Education Plan (IEP) Team, as appropriate.

---

**TO BE COMPLETED BY PUBLIC SCHOOL WHERE STUDENT IS CURRENTLY ENROLLED:**

Student Name: _____ Student #: _____

Last Day of School Attendance _____ Current ESE Program(s): _____

Student's Schedule *(Core Classes)*

Course # _____ Course Title _____ Current Grade _____ Teacher _____

Course # _____ Course Title _____ Current Grade _____ Teacher _____

Course # _____ Course Title _____ Current Grade _____ Teacher _____

Course # _____ Course Title _____ Current Grade _____ Teacher _____

I am aware that this student is applying for the Hospital/Homebound Program. The following information should be considered in the determination of eligibility for the Hospital/Homebound program.
*(Please explain)*

_____ _____

**Principal or Designee's Signature** **Date**

(**NOTE:** *Provision of incomplete information below may delay application process)*

# Suwannee County School Board

## Hospital Homebound Request

1740 Ohio Avenue South Live Oak, FL 32064
Phone 386-647-4630 or FAX 386-208-8687

## Re-Admittance to School

*(to be completed by the treating physician/ARNP/PA)*

**Today's Date** _____

**Student Name**_____ **DOB**_____
**Last** **First** **MI** ***(PLEASE PRINT)***

**Parent/Guardian Name** _____

## To be completed by the Physician/ARNP/PA

As of today's date _____, I have treated the above named student has been released and is clear to return to school.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | This student is now free of communicable disease and/or is in stable condition to attend school. |
| ☐ | ☐ | This student must take precautions or limitations for a period of time? If so, please explain: |

## Additional Information

_____ _____ _____
**Physician/ARNP/PA Signature** **Print Name of Physician/ARNP/PA** **Date**
*(must be original, stamps are not accepted)*