BIBB COUNTY SCHOOL DISTRICT

EMPOWERED TO LEARN, LEAD, INNOVATE AND SERVE

Licensed Physician/Psychiatrist Statement and Medical Referral Form

(Note: This form must be completed by a physician or psychiatrist licensed by the State of Georgia.)

Physician/Psychiatrist Name: _____ GA License #: _____
Address: _____City_____, GA Zip _____
Phone Number: _____ Fax: _____

Student Information
Student Name: _____ M ☐ F ☐
Address: _____ Date of Birth: _____
Parent/Guardian: _____
Phone: H _____ W _____ C_____

Section A. Physician/Psychiatrist Statement and Diagnosis
Pregnant students will not be approved for HHB services until after the delivery, unless there are medical complications which prevent school attendance. Students diagnosed with a contagious disease will not be served while contagious.
Patient's Diagnosis and Description:
_____
_____ Chronic Illness Y ☐ N ☐

Pregnancy Y ☐ N ☐ Expected Due Date _____ Complication of Pregnancy Y ☐ N ☐

Name of Hospital: _____ City_____ State _____

Estimated Duration of HHB Services:
Please note that HHB students DO NOT receive daily instruction from their school-based teachers. Instead, HHB students receive a total of 3 hours of instruction per week from a designated teacher. HHB is not intended to replace the instruction received in a traditional setting. Please ensure that HHB services are necessary for the student's health, as these services are not designed to be the best academic option for students that can be accommodated in a traditional setting.

HHB Start Date: _____ HHB End Date: _____

Date of Initial Evaluation: _____ Date of Next Scheduled Appointment: _____

NOTE: You may be asked to periodically verify that the student remains under your care and continues to qualify for the HHB services program.

Student's Name: _____ DOB: _____

Physician's Statement:
Could the student attend school with accommodations? Y ☐ N ☐

Recommendations for Accommodations:

_____

_____

_____

Is the student unable to attend school for a minimum of ten consecutive school days? Y ☐ N ☐

Will the student be able to engage in instruction during this time of confinement? Y ☐ N ☐

Could the student attend school regularly and receive HHB services on an intermittent basis as the diagnosis warrants? Y ☐ N ☐

Is the student confined to the home or hospital? Y ☐ N ☐

Is the student free from communicable diseases? Y ☐ N ☐

Can instruction be provided to the student without endangering the health and welfare of the teacher or other students whom the teacher may contact? Y ☐ N ☐

Treatment and School Reentry Plan
The following information is required to determine eligibility for HHB services and must be completed by the licensed physician or licensed psychiatrist who is currently treating the student for the diagnosis presented.

What is the scheduled frequency of treatment/therapy for this student?
Daily ☐ Weekly ☐ Monthly ☐

What is the expected duration of the treatment/therapy? _____

Will the student take medication? Y ☐ N ☐

Name of medication (or attach list)	Effects on student's ability to comprehend	Effects on student's ability to complete independent assignments	Effects on student's ability to relate to teachers and other students

Student's Name: _____ DOB: _____

Could this student return to school on an intermittent basis after his or her medication and condition is stabilized? Y ☐ N ☐

Can this student come into contact with other students? Y ☐ N ☐

The HHB services program is designed to be a temporary educational program to help students who are unable to attend school for medical or psychiatric reasons. Please describe your time frame and transitional plan for the student's reentry to school (attach additional pages as needed).

_____

_____

_____

Physician's Certification: I certify that this student is under my care and treatment for the aforementioned medical condition. My recommendation has been based on the medical needs of the patient, keeping in mind that the least restrictive environment is preferred.

_____

Physician Printed Name Physician Signature Date

_____

Advanced Practice Provider (on behalf of licensed physician) Date

Return Completed Form to:

Counselor's Name_____

School's Name _____

Email Address _____

Fax Number _____

The Georgia Composite Medical Board provided information on the following statute: O. C. G. A. 43-34-25, regarding Advanced Practice Providers signing health forms for educational purposes. The law states:
(e.1) Except for death certificates and assigning a percentage of a disability rating, an advanced practice registered nurse may be delegated the authority to sign, certify, and endorse all documents relating to health care provided to a patient within his or her scope of authorized practice, including, but not limited to, documents relating to physical examination forms of all state agencies and verification and evaluation forms of the Department of Human Services, the State Board of Education, local boards of education, the Department of Community Health, and the Department of Corrections.
***Note:** The Advanced Practice Provider may only provide this service if the Physician delegates these duties and is in agreement with the diagnosis.