Brantley County Schools
Hospital/Homebound Services
Pregnancy and Delivery
Physician Verification Form

Student's FULL Name: _____

Grade: _____ School: _____DOB: _____

Address: _____

Parent/Guardian: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Obstetrician's Name: _____ GA License #: _____

Address: _____Phone: _____

Note: The student may attend school up until the actual delivery date. The attending physician must complete the Hospital/Homebound Services Medical Referral Form if the student is put on bed rest or is hospitalized prior to giving birth.

Actual Delivery Date: _____

_____ is not able to attend school beginning _____ and
(Student's Name)

ending _____.

Physician's Comments:

_____

_____

Physician's Signature: _____ **Date**: _____

For School Use Only

Services Recommended (check one): ☐ Long-term ☐ Intermittent ☐ Temporary

Estimated Duration of HHB Services: Start Date_____ End Date _____ # Weeks _____

Principal / HHB Designee Signature: _____ **Date**: _____

Date Parent Notified of Approval/Denial: _____ **Date SPED Notified** (if applicable) :_____

Date of Educational Service Plan (ESP) Meeting: _____ **Location**: _____

STATE MANDATED TESTING

Please select the state mandated tests that apply to the student mentioned above that will be administered while he/she is receiving HHB services. Discuss with school test coordinator.

☐	☐	☐	☐	☐	☐	☐	☐	☐
GKIDS	**CRCT**	**Gr. 5 Writing**	**Gr. 8 Writing**	**GAA**	**GHSWT**	**EOCT**	**GHSGT**	**ACCESS for ELLs**

For CENTRAL OFFICE Use Only

Date HHB Application Received at BOE Central Office: _____ **By:** _____

☐ **APPROVED** _____ thru _____

☐ **NOT APPROVED Reason:** _____

_____ **H.B. Instructor:** _____

HHB Coordinator's Signature