RESET FORM

PGCPS
Office of Home and Hospital Teaching
301-567-8642| home.hospital@pgcps.org
8437 Landover Road|Landover, MD 20785

PHYSICIAN'S VERIFICATION: Physical Conditions

Parent/Guardian:
Home and Hospital Teaching (HHT) supports students who have a physical condition that renders them **unable** to attend school. This form must be completed by the **licensed physician** or **licensed nurse practitioner** caring for the student named in this form. School personnel may need to contact the referring physician for additional information necessary to determine eligibility. Services may be denied if the medical provider cannot be reached within **three school days** of the initial attempt to make contact. HHT is a **temporary** support for a student experiencing a physical condition. It is **not daily classroom instruction**. Approved students may receive 6 hours of support **per week** compared to 30+ hours of instruction provided in school. **Prince George's County Public Schools does not offer online or virtual school in lieu of regular school attendance.**

Parent Signature: _____ Date: _____

Student Information:

Student Name: _____ Date of Birth: _____

Grade: _____ PGCPS ID#: _____ School: _____

Medical Information for Home & Hospital Teaching(HHT) Determination
(Student's Medical Provider Completes)

1. **Medical diagnosis that will prevent the student from attending school for 20 or more days. If necessary, attach additional documentation** to aid the district in determining why accommodations at school are not appropriate for the student. **This form is valid for 60 calendar days from the date of the physician's signature.**

2. Based on this diagnosis named in item #1, the student is (**check one**):
   - ◯ Unable to attend school for more than **20 consecutive school days.**
   - ◯ May attend school intermittently as medical condition permits.

3. If the student is **unable to attend school, explain** why the student's medical condition prevents the student from attending school. (additional information may be attached).

   _____

   _____

4. If the student **can attend intermittently as health permits,** explain the medical supports the student may need to attend school.

   _____

   _____

5. I am the healthcare provider who will be treating and continuing the treatment or supervision of this student. ☐ **NO** ☐**YES**
6. Date of most recent appointment with student named above _____.
7. Is the student currently taking medication for the medical condition in item #1? ☐ **NO** ☐ **YES**
8. Provide the names of the medication and dosage. _____
9. **For Pregnant Students —- Expected Delivery Date:** _____
10. **Proposed HHT begin date** (Date must be a date after the medical provider's signature below): _____
11. **Proposed HHT end date NOT to exceed 12 weeks**: _____

Health Care Provider Verification:

Name and Title (Print): _____ Signature: _____ Date: _____

☐ Licenced Physician ☐ Licensed Nurse Practitioner

License Number: _____ Contact Phone Number: _____

This form is valid for 60 days from the date of the physician's signature.

REV 6.26.2026