Homebound Instruction

Homebound instruction is provided when a student is unable to attend school due to a verified medical reason which may include mental health issues. Below identifies the roles and responsibilities of parties needed to provide Homebound Instruction according to (CTSDE Sec. 10 – 76d-15).

Student's School
- Provides Parent with the Homebound Instruction Packet.

Parent/Guardian
- Completes the SR7 form (This form is valid for 1 year.)
- Provides the Physician with:
    - SR7 form (filled out and signed by parent/guardian) and
    - The Homebound Instruction Referral (HIR) form.

Physician
- **MUST Complete** The Homebound Instruction Referral (HIR) form
- Fax or mail **SR7 and HIR form** to:

  Moira Bryson, PHNII
  888 Washington Blvd
  City of Stamford Health Department, 8th FL
  Stamford, CT
  P: (203) 977-4370
  F: (203) 977-5707

City of Stamford Health Department
- Review HIR form
- Approve or Disapprove request for Homebound Instruction
    - Notifies parent and Laura Greene, Coordinator of Alternative Education, that student is approved
    - Notifies parent and school if approval is NOT granted

Laura Greene
- Assigns a tutor (if approval granted by Health Department)
- Provides parent/guardian with tutor name and contact information

Tutor
- Contacts parent/guardian to coordinate time and days of tutoring (10 hours per week)
- Tutoring begins

NOTE: Students with IEPS: A PPT MUST occur prior to tutoring to specify the child's educational program for Homebound Instruction and to modify the IEP accordingly.

STAMFORD PUBLIC SCHOOLS
CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

I, ____, give consent to Stamford Public Schools, to release information to and obtain information from ____, in regard to (child's name) ____, D.O.B.______________________.

The above-named agency or individual provider's address is ____

____________________________________, and contact information is ____________________________________

Type of Information

- ☐ Medical
- ☐ Psychiatric/Mental Health
- ☐ Academic
- ☐ Behavioral
- ☐ Other (specify):____

THE PURPOSE FOR REQUESTING THIS INFORMATION IS:

____

Date of expiration for this consent: one year from the date of parent signature.

I understand that I may revoke this consent at any time by notifying Stamford Public Schools in writing. Any information gathered or released prior to the revocation of this consent is valid and cannot be voided. I also understand that, even if I do not revoke this consent, the consent will expire at the end of the year.

____ ____ Signature of
Guardian Signature of School Personnel

____ ____ Relationship to
Child Title

____ ____ Date Date

____
Stamford Public Schools Contact Name

____
Stamford Public Schools Contact Title and Date

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

1. This form should be filled out:

   a. Whenever a student withdraws from a school or program Form SR-7 must be given to the parent or legal guardian.

   b. When any information identifiable to a particular student is requested by an agency outside the Stamford Public School system, Form SR-7 must be completed.

   c. When parents request copies of records for themselves or outside agencies.

2. Form SR-7 can only be completed by the student over 18, the parent or legal guardian.

3. The original is to be placed in the student's cumulative folder for non-handicapped students. 4.

The original is to be placed in the student's PPT folder for handicapped students.

5. A copy of completed Form SR-7 is to be given or sent to parent.

6. A copy of completed Form SR-7 is to accompany the record to the agency.

7. The name of the staff member in whose presence Form SR-7 is completed — or receiving the completed Form SR-7 – is to be recorded before any record is released.

must be recorded on Form SR-9, Log of Access.

Date: Approved ____________

Declined ____________

HOME INSTRUCTION REFERRAL FORM

Homebound Instruction
Request for Medical or Mental Health Reasons
Hospitalization Instruction

To All Physicians and Mental Health Professionals:
Please send this form and the SR7 form provided to you by the parent directly to:

Moira Bryson, PHNII
888 Washington Blvd
City of Stamford Health Department, 8th FL
Stamford, CT
P: (203) 977-4370 F: (203) 977-5707

Student Information
Student Name ____ DOB ____________________

Home Address ____

Student's District School ____

Physician Information
Treating Physician or Mental Health Professional

____

Address____

Phone __________________ Email____________________ Is the student able to attend school? Yes

No

Will the student be absent for at least 10 consecutive school days or that the child's condition is such that the child may be required to be absent for short, repeated periods of time during the school year short term absences throughout the year? Yes No

Does the student have a verifiable medical or mental health reason for this request? Yes No What is the

student's current diagnosis? ____

Expected date the student will be able to return to school ____
Student's expected return date must not exceed three (3) months. A review is necessary past three months.

I have consulted with the school district's health supervisory personnel at (203-977-4373) and have determined that the student's attendance at school with reasonable accommodations is not feasible. Yes________(initials)

Please include information pertaining to the diagnosis to include supporting documentation if possible.

Signature (Treating Physician or Mental Health Professional).

_____________________________________ Date _____________________________

***PLEASE NOTE:** If a dispute arises, the child will receive instruction until the matter is resolved provided the SR7 is current. If the SR7 does not exist or the parent has revoked consent, the instruction stops.