HOME INSTRUCTION APPLICATION -YELLOW SPRINGS SCHOOLS

Mills Lawn Elem. 200 S. Walnut St. Ph.(937)767-7217; FAX (937)767-6602
YSHS/MMS: 420 E. Enon Rd. Ph. (937)767-7224; FAX (937)767-6154
Yellow Springs, Ohio 45387

THIS SECTION TO BE COMPLETED BY THE STUDENT/PARENT(S):

Name of Student:____Date of Birth:____________________

Address:____
Street City Zip

Parent 1 Name:_______________________________Work Phone:______________Cell Phone: ________________

Parent 2 Name:_______________________________Work Phone:______________Cell Phone:________________

Parent 1 Email address:____________________________ Parent 2 Email Address:___________________________

Building of Attendance _________________Grade:________

Offer of Home Instruction____ accepted or ____refused by: ____

Parent Signature and Date

THIS SECTION TO BE COMLPETED BY SCHOOL PERSONNEL:

Special Education Team Placement: ____YES, No Physician Information Needed ____ NO, Physician Must Complete

Physician's Request for Student Home Instruction

Dear Physician,

This student and her/his parent/guardian have requested home instruction for the above-named student. This service will be provided only upon your verification that the above-named student has a physical or mental condition which prevents this student from having regular school attendance.

This form needs to be completed and submitted to the Yellow Springs District before the student can start home instruction. Please note that:

✓ *The student will receive up to of five hours of instruction a week.*
✓ *You must provide an estimation about when the student will be able to return to school;*
✓ *If the student will be out for longer than nine weeks further documentation will be required about the student's continued need for home instruction.*

If you have any questions, comments, or concerns please contact____.

Thank you.

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN:

Name of Physician: ____

Address: ____

Phone Number: _________________________________ **Fax Number:** _____________________________

Date of the Physical Examination: ____

Student's Diagnosis: ____

Does the student's physical and/or mental condition prevent her/him from attending school on a full-time basis?

☐ Yes ☐ No

Does the student's physical and/or mental condition prevent her/him from attending school on a part-time basis?

☐ Yes ☐ No

If you answered "yes" to either of the questions above, please indicate the date upon which you anticipate that the student will be able to return to school on a full-time basis: ____

Physician's Signature: ____**Date:** __________________________

Date this form was received by Yellow Springs School District: ______________________________________