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: _____