Application for Home/Hospital Instruction

Please type or print neatly

Parent/Student Information

Section I

To be completed by the parent(s)/guardian(s) prior to full completion by the licensed medical or mental health professional.

School District_____School_____Grade_____

County of Residence_____ Last Date Attended_____

Name of Student_____Date of Birth:_____

Address of Student_____Zip Code:_____

Sex _____ Race _____ Social Security #_____Telephone_____

Special Education Student? Yes ☐ No ☐

If yes, list of programs student is enrolled:

_____

Full name of Father/Guardian_____Phone_____

Full Name of Mother/Guardian_____Phone_____

Directions to Home:

Pursuant to KRS. 159.030, Section (2), Before granting an exemption under subsection (1)(d) of this section, the board of education of the district in which the child resides shall require satisfactory evidence, in the form of (a)
A signed statement of a licensed physician, advanced practice registered nurse, psychologist, psychiatrist, chiropractor, or public health officer, that the condition of the child prevents or renders inadvisable attendance at school or application to study. On the basis of such evidence, the board may exempt the child from compulsory attendance. Any child who is excused from school attendance more than six (6) months shall have two (2) signed statements from a combination of the following professional persons: a licensed physician, advanced practice registered nurse, psychologist, psychiatrist,
chiropractor, and health officer, except that this requirement shall not apply to a child whose treating physician, advanced practice registered nurse, chiropractor, or public health officer certifies that the student has a chronic physical condition that prevents or renders inadvisable attendance at school or application to study and is unlikely to substantially improve within one (1) year; or (b) An individual education plan specifying that placement of the child with a disability at home or in a hospital is the least restrictive environment for providing services. Exemptions of all children under the provisions of subsection (1)(d) of this section shall be reviewed annually with the evidence required being updated, except that for
an exceptional child who se treating physician, advanced practice registered nurse, chiropractor, or public health officer certifies that the student has a chronic physical condition unlikely to substantially improve within three (3) years, the child's admissions and release committee shall annually consider the child's condition and the existing documentation to determine whether updated evidence is required. Updated evidence shall be provided for a child upon determination of need by the admissions and release committee, or at least every three (3) years.

Pursuant to 704 KAR 7:120, the condition of pregnancy is not to be considered a physical or health impairment in and of itself and the nature and extent of any complication shall be delineated prior to consideration of home/hospital instruction for this condition.

Release of Information

I understand that the Home/Hospital Review Committee may request a review of the information provided on these forms by local health personnel. I hereby authorize this committee to have access to pertinent information regarding this request.

_____ _____

Parent/Guardian Signature Date

Application for Home/Hospital Instruction

Professional Statement

Section II

This section is to be filled out by the authorized medical or mental health professional.

It shall be determined that a child or youth is to be provided home/hospital instruction if the condition of the child or youth prevents or renders inadvisable attendance at school as verified by signed professional statement in accordance with KRS. 159.030 (2) and 704 KAR 7:120.

Please Note: Home instruction (homebound) is short-term instruction provided in a home or other designated site for a student who is temporarily unable to attend school. According to state guidelines, two hours of home instruction each wee is the equivalent to one full week of school attendance. Home instruction is not designed to take the place of a more appropriate school placement.

Name of Student _____

Please Check one of the following:

☐ The student can attend school without any type of modifications or special provisions. I do not support Home/Hospital Instruction

Comments:

☐ The student can attend school only with modification or special provisions. I do not support Home/Hospital Instruction.

Modifications:

☐ The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction.

If you do support Home/Hospital Instruction, please fill out:

Diagnosis _____ Prognosis _____

Special Reason(s) why the student is unable to attend school at this time:

How long have you been seeing the patient for the diagnosis listed?

Approximate length of time student will need Home/Hospital Instruction:

Please summarize test and all other data collected that supports the need for Home/Hospital Instruction at this time:

What is the treatment plan for the patient:

What is the expected duration of treatment:

☐ Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year.

What ancillary services are involved in treatment:

List consultants/specialists to whom this student has been referred:

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Will you be following the patient? Yes☐ No☐. If not, who will? _____

Anticipated date of student's return to school:

What are your recommendations to assist this student in his/her return to school:

Additional Remarks:

_____ _____ _____

Signature of Licensed Professional Title Date

Office Address:

Office Phone:
Office Fax:

Home/Hospital Review Committee

Section III

This section is to be completed by the Home/Hospital Review Committee.

Name of Student _____

Date Application Received: _____

☐ Approved ☐ Denied ☐ Incomplete

If Approved, date of services will be from _____to _____

If eligibility for services denied, reason for denial:

If incomplete application, type of additional information requested:

Date of Request _____Person Contacted_____

Signature of Committee Members

Director of Pupil Personnel _____ Date _____

Home/Hospital Services Teacher
or Program Director _____ Date _____

Local Medical or
Mental Health Personnel _____ Date _____

Comments: