Sayville Public Schools
99 Greeley Avenue
Sayville, NY 11782

REQUEST FOR EXTENSION OF HOMEBOUND INSTRUCTION:

All requests to extend homebound instruction must be received by the Office of Instruction no later than 2 weeks prior to the approved end date. This packet must be completed in its entirety.

Page 1 is to be completed by person making request for homebound instruction.

Please check the reason for the request:

_____Medical Reasons _____CSE/504 Determination _____Out of School Suspension
_____ Superintendent's Hearing_____ Other: _____

Name of Child:
_____
(Last) (First) (Middle) (D.O.B)

Parent/Guardian:_____
(Last) (First)

Legal Residence of Child:_____
(Number, Street, Town)

Telephone: Home:_____ Work:_____ Cell: _____

School: _____ Grade: _____ Homeroom Teacher:_____
Person making request: _____ Date of request: _____

To be completed by the parent:
Please explain the reason for the need to extend homebound instruction.
_____
_____

Is your child still seeing the same treating health care provider?: _____
If so, do you believe he/she has made progress toward the goal of returning to school?:
_____
If your son/daughter is being treated by a new health care provider, please submit a new treatment plan.
If your son/daughter continues to be treated by the same health care provider, please have him/her complete the questions below.

If your son/daughter has a new healthcare provider, please provide your consent for the school to communicate with the student's healthcare provider(s):
I consent to the release of information from the Health Care Provider(s) to the District. Please note that a HIPAA-compliant authorization for release of health information is included as part of this packet. If requesting an extension of homebound instruction for medical reasons, you are encouraged to complete and return a HIPAA authorization for release of information by the student's health provider(s) to the District and/or the District's school physician.

_____ _____
(Signature of Parent/Guardian) (Date)
Name and phone number of Health Care Provider(s): _____
_____

PROVIDER'S STATEMENT OF INCAPACITATING CONDITIONS

(This page must be completed by the Health Care Provider)

Request for Extension of Homebound Instruction

Students who request homebound services will not be in attendance at their present school. In place of the regular academic setting, the middle or high school student will receive instruction at home in the form of two hours per week per academic subject. Elementary students will receive one hour per week per academic subject.

Student Name: _____ DOB: _____
Diagnosed Condition: _____

Recommended Period of homebound instruction:

Recommended start date: _____ Recommended end date: _____

Physical restrictions/limitations caused by the diagnosed condition:

A. The movements and activities the patient can do (include maximum length of time) are:

B. The movements and activities that should not be done are:

Circumstances that are harmful to the student (weather conditions, time of year, etc.):
_____

List all prescribed medications: _____
*Social/emotional concerns:_____ A treatment plan must be attached for all social/emotional concerns.

Have the parents or guardians been advised of any further medical examinations or treatments that may be needed? If so, please indicate to whom the patient has been referred.
_____
_____
_____
Additional Information/updates:
_____
_____

Physician's Stamp Here:

Physician's Original Signature:_____
Address:_____
Date of Examination:_____

REQUEST FOR EXTENSTION OF HOMEBOUND INSTRUCTION

**Update to Treatment Plan for Social/Emotional Conditions

To be completed by the Treating Health Care Provider:
Based on the initial treatment plan, please provide information regarding progress toward short term and long term goals. _____
_____
_____

Have there been any changes to the treatment plan pertinent to this request? If so, please explain.
_____
_____
_____

How often has the student attended treatment sessions since the last request for homebound instruction? Has attendance been consistent?
_____
_____

Do you continue to recommend homebound instruction? If so, how much longer?
_____
_____
_____

What information are you using to determine that the student is ready to return to school?:
_____
_____
_____

Have the parents or guardians been advised of any further medical examinations or treatments that may be needed? If so, please indicate to whom the patient has been referred.

Physician's/Health Care Provider's Original Signature:_____
Address:_____
Date of Examination:_____
Physician's Stamp Here:

**If this student is being treated by a new health care provider, please provide a new treatment plan on following page.

Treatment Plan for Social/Emotional Conditions

Student Name:	DOB:
Treating Health Care Provider:	Treatment Plan Date:
Signature:	Date:

Other Agencies Involved:	**Plan to Coordinate Services:**

Medication(s):	**Dose:**	**Frequency:**	**Indication:**

Problem/Symptom:

Long Term Goal:

Short Term Goals/Objectives:	**Date Established**	**Projected Completion Date**	**Date Achieved**

Intervention/Action (How often does the student attend your treatment sessions? Is the family involved in treatment? Do you recommend additional actions?)	**Responsible Person(s)**

FOR SCHOOL USE ONLY

ALL information MUST be completed and ALL signatures are required.

The child named on this application is a registered student of this school. This application including a completed "Statement of Physician" has been reviewed by members of the school staff as certified by their signatures below.

Principal or Guidance Counselor MUST attach student's course schedule and indicate specific courses to be tutored and exams that need to be administered.

To be completed by Principal/Assistant Principal:

It is recommended that Homebound Instruction be provided (typically no more than 6 weeks):

Start Date: _____ End Date:_____

Courses to be tutored:

_____ _____
_____ _____
_____ _____
_____

Signature of Principal/Assistant Principal: _____ Date:_____

_____

Recommendation of the Director of Student Services:

Homebound instruction has been approved from (Start Date): _____ (End Date):_____

An updated application packet is due back to the Instructional Services Office two weeks prior to this end date if that parent is requesting an extension.

Signature of Director of Student Services _____

Date: _____