Grand Island Central School District
1100 Ransom Road • Grand Island, New York 14072
Telephone (716) 773-8800 • Fax (716) 773-6279
www.grandislandschools.org

MEDICAL REQUEST FOR HOME INSTRUCTION

TO BE COMPLETED BY TREATING PHYSICIAN and/or TREATING PSYCHIATRIST

HOME/HOSPITAL PROCEDURES

- To request home, hospital, or institutional instruction for a resident student, the parent or guardian must submit a request to the Pupil Personnel Office that includes written medical verification from the student's treating medical doctor demonstrating the student's anticipated inability to attend school in person for at least ten days during the next three months and written consent authorizing the Director of School Health Services or designee to contact the student's treating healthcare provider. Refusal to provide this written consent will result in a denial of the request for home, hospital, or institutional instruction.

- The request and consent will be forwarded to the Director of School Health Services who will review the need for home, hospital, or institutional instruction and will work with the school district to approve or deny the request. During this review, the Director of School Health Services may contact the student's treating medical doctor to obtain additional information necessary regarding the student's health or mental health.

- After receipt of written medical verification from the student's treating medical doctor the District will notify the parent or guardian whether their request for home, hospital, or institutional instruction has been approved or denied. In the case of a denial, reason(s) for denial will be provided.

- Parents and guardians may appeal the denial of home, hospital, or institutional instruction to the District's Board within ten school days of receipt of notification of the denial. Home, hospital, or institutional instruction will be provided while an appeal is pending before the District.

- All Home/Hospital requests will be reviewed on an individual basis. The goal is to have our students instructed in a school environment where they can be the most successful.

Effective 1/15/2024

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_____, _____, is under my care for:
Student's name DOB

_____ Generalized Anxiety Disorder

_____ Social Anxiety Disorder - Social Phobia

_____ Separation Anxiety Disorder

_____ Specific Phobia

_____ Panic Disorder

_____ Posttraumatic Stress Disorder

_____ Depression

_____ Other Health Condition - _____
Treating diagnosis

Is the patient being treated by a mental health agency or psychiatrist? YES ( ) NO ( )

If Yes – list the mental health agency or psychiatrist: _____

What limitation does this diagnosis cause?

_____

If age appropriate, is this student currently employable during the treatment phase?

YES ( ) NO ( ) Not Age Appropriate ( )

How does this affect the student's ability to attend school?

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What is the treatment plan to improve the student's condition? (Please check all that apply):

___Outpatient Counseling __Medication Management ___Gradual or Full Reentry in School

___Other (Please specify) _____

The Grand Island Central School District believes it is in every student's best interest to receive their education in the classroom during regular school hours, when counselors', social workers', psychologists', and school nurse services are available to them. Home instruction, no matter how talented the educator, cannot replace the benefits of education in a classroom setting. Only a maximum of 4 weeks at a time will be approved as the treatment plan is implemented.

In keeping with our goal to return the student back to school as quickly as possible, do you feel that this student is capable of a shortened school day, instead of OR in addition to home instruction?

_____ Yes, with a maximum of _____ hours per day.

_____ No, not at this time.

If you are recommending that the student needs full home instruction; when do you believe the patient may begin gradual re entry back into school? (Gradual re entry may include a shortened day in the school for a few periods of instruction.)

Indicate when you believe the student will be able to tolerate gradual reentry into school:

_____

_____ _____
Provider name printed Medical Office

_____ _____
Provider Signature Office Phone number

_____
Date

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2023-2024 School Year
Consent to Release Health or Mental Health Information

I (we) authorize Dr. Daryl Ehlenfield, Director of School Health Services, to contact my (our) health provider to obtain information regarding the request for home instruction for

_____.
(name of student-please print)

_____ _____
Name of parent/guardian (please print) Signature of parent/guardian

_____
Date

FOR OFFICE USE ONLY:

- ☐ Approved
- ☐ Not approved

Explanation: _____

_____

_____

Signature: _____ Date: _____