



KEYSTONE CENTRAL SCHOOL DISTRICT

86 Administration Drive, Mill Hall, PA 17751
Phone: (570) 893-4900 • Fax: (570) 748-3597
Web: www.kcsd.k12.pa.us

APPLICATION FOR HOMEBOUND INSTRUCTION

Name of Child: _____ Parent/Guardian: _____

Address: _____

Current School: _____ Date of Birth: _____

I hereby apply for Homebound Instruction for my daughter/son, _____
(Child's Name)

Who is unable to attend school due to medical reasons. I understand that:

The State Board of Education Regulations, Chapter 11, §11.25 state that a school district, area vocational-technical school or charter school may excuse a student from attendance on a temporary basis . . . Temporary excusals may not exceed three months.

I further understand that:

Should there be a need for a continuation for homebound instruction after this initial period, the student will need to be re-evaluated by his/her physician and another *Physician's Statement Regarding Homebound/Handicapped* will need to be submitted to the Keystone Central School District Attendance Office. This 2nd statement should be obtained around the end date of the initial period. If I anticipate the need for an extension, I will schedule the doctor's appointment in advance of this end date. KCS D must submit extension requests to the PA Department of Education who will then approve or disapprove them. Extension requests must contain a detailed medical need.

I have included a completed *Physician's Statement Regarding Homebound/Handicapped* with this application.

Signature of Parent/Guardian: _____ Date: _____

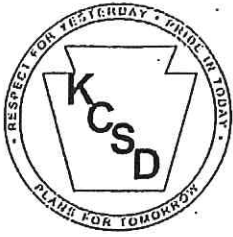
Address: _____ Phone: _____

Homebound is a partnership between home and school which is supported by a physician, psychiatrist and/or psychologist to address the student's academic needs during this temporary time frame.

I _____ am giving permission for the school and the physician, psychiatrist and/or psychologist who is completing this form to exchange information regarding my student named above.

I understand that this ensures that all parties involved are working towards the best educational outcome for my student named above.

Signature of Parent/Guardian: _____ Date: _____



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PHYSICIAN'S STATEMENT REGARDING HOMEBOUND/HANDICAPPED

Homebound Instruction is provided to students whose physical condition prevents them from attending school. A physician must provide the following:

1. A diagnosis of the condition
2. A statement that explains why it would be harmful for the student to attend school or that the student would be unable to benefit from school because of the condition
3. An explanation of the student's treatment plan to improve their condition to get them back into school
4. An indication of the length homebound instruction will be needed (not to exceed 3 months)

Name of Student: _____ Parent/Guardian: _____

Address: _____

_____ Date of Birth: _____

I find the above named student to have the following medical condition/disability (if the student presents with an exceptional condition, please complete other side):

Diagnosis: _____

Description of Condition/Diagnosis and why it would be harmful for the student named above to attend school or why they would not benefit from receiving their education in school: _____

Explanation of the treatment plan the above named student is participating in to improve condition/diagnosis so the student may return to school: _____

Recommended date for homebound instruction to begin: _____

Approximate length of time child will be homebound: _____

Limitations: _____

Maximum number of hours of instruction per week: _____

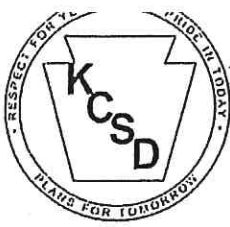
_____ Date: _____

(Physician's Signature)

(Physician's Name- PRINTED)

Physician's Address: _____

Physician's Phone Number: _____



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EXCEPTIONAL CONDITIONS

1. In order for a student with a social and/or emotional condition to receive homebound instruction, a psychologist or psychiatrist must state in writing that it would be harmful to the mental health of a student to attend school.

a. Homebound is a short-term support provided to the student. If the student is experiencing symptoms in which the psychologist or psychiatrist feel would last longer than three months, please list the other alternatives discussed with the student: _____

Diagnosis: _____

Description of Condition/Diagnosis and why it would be harmful for the student named above to attend school or why they would not benefit from receiving their education in school: _____

Explanation of the treatment plan the above named student is participating in to improve condition/diagnosis so the student may return to school: _____

Recommended date for homebound instruction to begin: _____

Approximate length of time child will be homebound: _____

Limitations: _____

Maximum number of hours of instruction per week: _____

(Psychologist's Signature) (Psychologist's Name- PRINTED) Date: _____

Psychologist's Address: _____

Psychologist' Phone Number: _____

(Psychiatrist's Signature) (Psychiatrist's Name- PRINTED) Date: _____

Psychiatrist's Address: _____

Psychiatrist's Phone Number: _____

2. Homebound instruction will not be provided for a pregnant student unless a physician will state in writing that if the student attends school it would be harmful to the health of the student and/or child. Please explain how attending school while pregnant would be harmful to the health of the student/and or child.

Diagnosis: _____

Description of why it would be harmful for the student's health and/or to their child's health to attend school.

Recommended date for homebound instruction to begin: _____

Approximate length of time child will be homebound: _____

Limitations: _____

Maximum number of hours of instruction per week: _____

(Physician's Signature) (Physician's Name- PRINTED) Date: _____

Physician's Address: _____

Physician's Phone Number: _____

(Administrative use below this line)

_____, who is medically unable to attend his/her
(Student's Name)
normally assigned school is _____ *approved* _____ *disapproved* for Homebound Instruction.

If *disapproved/approved*, indicate (reason or length of time) _____

_____, Director of Pupil Services _____
(Signature) (Date)

Received by KCSD on: _____