

REQUEST FOR HOME INSTRUCTION APPLICATION

STUDENT INFORMATION			
Last Name:		First Name:	
Date of Birth:		Grade Level:	
School Building:		Building Administrator:	
PARENT/GUARDIAN INFORMATION			
Last Name:		First Name:	
Home (Physical) Address:		Apt. #:	
City:		State:	Zip Code:
Home Telephone:	Alternate Telephone:	E-mail:	

REQUEST FOR HOME/HOSPITAL/INSTITUTIONAL OR HOMEBOUND INSTRUCTION	
<p>My child is currently (choose one):</p> <p><input type="checkbox"/> Attending a district school</p> <p><input type="checkbox"/> Attending a non-public school</p> <p><input type="checkbox"/> Homeschooled</p>	<p>My child is (choose one):</p> <p><input type="checkbox"/> A student with a disability and an IEP or 504 Plan</p> <p><input type="checkbox"/> <u>Not</u> a student with an IEP or 504 plan at this time</p>
<p>Instruction Requested (Please choose one):</p> <p><input type="checkbox"/> Home or Homebound</p> <p><input type="checkbox"/> Hospital (identify name/address/contact for where your child is being treated):</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Institution (identify name/address/contact for program where your child is currently located):</p> <p>_____</p> <p>_____</p>	
<p>I request that you consider the following for my child (you may check more than one):</p> <p><input type="checkbox"/> In-Person Tutoring</p> <p><input type="checkbox"/> Virtual Tutoring</p> <p><input type="checkbox"/> Hybrid In-Person and Virtual Tutoring</p> <p><i>If approved, the district will make the final determination on how instruction will be delivered.</i></p>	

REQUIRED MEDICAL VERIFICATION

Any application or request for home/hospital or institutional instruction due to a temporary or chronic physical, mental, emotional illness or injury must be supported by written medical verification from the student's treating health care provider that outlines the condition and reasons that the student is unable to participate in their usual educational setting due to such condition for at least ten (10) days during the next three (3) months. The verification must include the anticipated duration of need for home instruction. Requests due to mental/emotional illness must include a treatment plan indicating a proposed school re-entry plan from the healthcare provider who is treating the student for the mental/emotional illness.

Additionally, you must consent to permit the school's medical director to communicate and consult with the health care provider submitting verification. Failure to provide consent will result in an automatic denial of the request. Please attach any relevant documentation including the treating healthcare provider's medical verification letter.

Authorization and Release to Communicate with Treating Health Care Provider

(Please complete, sign, and date below)

I, _____ (name), parent/legal guardian of _____ (student), authorize the _____ (school district) medical director to contact my child's treating health care provider (listed below) regarding their medical verification letter and my child's physical, mental, emotional illness or injury related to this application. I agree, as necessary, that I will also sign any reciprocal consent form or authorization required by my child's health care provider to permit such communication. This authorization is valid for 12 months, unless revoked in writing. I understand that if I revoke this authorization in writing, and submit such revocation to the district, that any disclosure or communication which occurred prior to such revocation was authorized at the time of disclosure.

Parent/Guardian Signature

Date

Print Name of Treating Health Care Provider

Print Treating Health Care Provider Address

Print Treating Health Care Provider Phone Number, E-mail and Fax Number

FOR OFFICE USE ONLY

Application reviewed date: _____

Parent/Guardian notified of decision date: _____

Approved

Denied

Appeal to BOE deadline (if applicable): _____