520 S. Washington St., Maryville, TN 37804 Phone (865)982-7121 Fax (865)263-8878

REQUEST FOR HOMEBOUND INSTRUCTION

To Be Completed By the Parent/Guardian

Student Name _____ Date of Birth _____

School _____ Grade _____

Parent/Guardian _____ Contact Number(s) _____

Address _____

Does this student receive special education services or have an Individual Education Plan (IEP)? _____

Purpose for requesting homebound services: _____

_____

_____

_____

Please note: A determination of the appropriateness of a temporary homebound placement will be made by school system personnel, considering the recommendation of the physician, as well as other relevant factors. Homebound is typically approved for 30 days. If homebound services are needed longer, a review will occur every 30 days. If approved for homebound services, a parent/guardian of this student, or other specified adult, must be present in the home while homebound instruction is taking place.

Adult to be Present _____

Relationship to Student _____ Phone _____

Parent/Guardian Signature _____ Date _____

This request cannot be processed without the following:

- A signed and dated Consent for Release of Student Records-Medical/Psychological form.
- A physician recommendation for homebound services must be completed by the medical professional who is treating the child for the condition that prevents the student from attending school.

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CONSENT FORM FOR RELEASE OF INFORMATION

Include all physicians, psychiatrists, hospitals, clinics, etc. that have had significant contact with your student. I hereby authorize the mutual exchange of information pertaining to _____ (student name) between the Maryville City School System and the following agencies:

Medical Professional(s) Information: (A Consent for Release of Records is required for each.)

Name _____Practice _____

Address _____Fax _____

Email _____ Phone _____

Specialist _____ General Practitioner _____ Pediatrician _____

Name _____Practice _____

Address _____Fax _____

Email _____ Phone _____

Specialist _____ General Practitioner _____ Pediatrician _____

Name _____Practice _____

Address _____Fax _____

Email _____ Phone _____

Specialist _____ General Practitioner _____ Pediatrician _____

- The specific records to be disclosed pertain to a request by the parent/student for homebound instruction due to a physical or mental health condition.
- This communication may be verbal or written.
- The purpose for making this request for information is to determine eligibility for temporary homebound instruction.
- The receiving party will not disclose the information to any other party without signed consent.

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release. If 18 or older, the student will sign below.

_____ _____ _____

Name (print) Signature Date of Signature

This release is valid for 12 months from the date of signature.