Saddle Brook Public Schools

355 Mayhill Street, Saddle Brook, NJ 07663
Phone: 201-843-1142
Fax: 201-843-0216

Mental Health Home Instruction Request Form

A student may be placed on home instruction when they are absent for 10 consecutive school days, and upon the approval of the school district's physician. A request for home instruction must be submitted by a student's physician, including the reasons and duration that the student is unable to attend school. A home instruction request begins with the submission of this form, which is completed by the parent and the student's physician.

Release of Information to District Staff

Section 1: Parent Completion
For the purpose of providing school based assistance to my child, and a review of our home instruction request, I am granting the following individuals to have permission to communicate with my child's Mental Health Provider indicated below

As per NJ6A:16.10.1, the school physician shall verify the need for home instruction and may contact the student's physician to secure additional information concerning the student's diagnosis or need for treatment, and shall either verify the need for home instruction or shall provide to the district Board of Education reasons for denial. The school district shall notify the parent concerning the school physician's verification or reason for denial within five school days after receipt of the written determination by the student's physician.

Mental Health Provider Name and Phone #	
District Staff indicated, and the Principal and School Counselor entered here:	Dr. Joseph Bellapianta, *District Physician* Mrs. Jaynellen Behre Jenkins, *Director of Planning/Research & Evaluation* _____, *Principal* _____, *School Counselor*
Date	
Parent Signature	

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To the Mental Health Provider:

This form is designed to gather essential information for a student's home instruction request due to a diagnosed mental health condition. We understand the complexity of these situations and appreciate your thoroughness in completing this document.

Please be advised that removing a student from school is a serious step with significant long-term implications. Prolonged absence often poses challenges for a student's successful reintegration into the school environment.

Home instruction provides a structured, less triggering environment for academic continuity ***while* intensive therapeutic work is undertaken.** Home instruction requests **will not be considered without a clear therapeutic plan** that will be worked on during their absence. Home instruction is considered the most restrictive educational setting, and the requested time is for treatment and crisis stabilization.

Please note the "Cycle of Avoidance and Relief": When a child avoids school due to distress, they experience temporary relief. This reinforces the avoidance behavior, making it increasingly difficult to return as the perceived threat (school) is not faced, and coping skills are not developed.

We will be contacting you directly to discuss this request. Only licensed LPCs, LCSWs, and Psychiatrists are authorized to complete this form. Treatment plans need to be updated every 30 days.

Mental Health Home Instruction Request Form	
Section 2: Student Information	
Student's Full Name:	
Student's Date of Birth:	
Student's Grade Level:	
Parent/Guardian Name(s):	
Parent/Guardian Address:	
Parent/Guardian Contact Number:	
Parent/Guardian Email Address:	

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Section 3: Medical Documentation To be completed by the treating LPC, LCSW, or Psychiatrist ONLY	
Provider's Full Name:	
Provider's Title:	
Provider's License Number:	
Office Address:	
Office Phone Number:	
Diagnosis:	
Date student started treatment with you:	
Date of student's last appointment:	
Date of next follow-up appointment:	
Symptoms: Enter below the description of symptoms that directly impair the student's ability to attend school and participate in the educational environment (e.g., severe anxiety, panic attacks, debilitating depression, social phobia, agoraphobia, etc.)	
Prognosis: Enter below the expected duration of the mental health condition and the anticipated need for home instruction (i.e., the student will return after completing a 4-week Partial Hospital Program; the student is adjusting to a new medication and is anticipated to return in 3 weeks; etc.)	

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Statement of Confinement: Enter below a clear statement indicating that, due to mental health conditions, the student is confined to the home or a hospital, or that the condition otherwise precludes their participation in the usual school setting. The doctor must certify that the student cannot attend school for more than 10 consecutive school days. ***I.e. I certify that _____ (student's name) is unable to attend school for more than 10 consecutive school days due to the aforementioned mental health condition and is confined to the home/hospital - OR the condition otherwise precludes their participation in the usual setting.***
Treatment Plan: Enter below a brief overview of the ongoing treatment (e.g., therapy, medication, management):
Have you been in touch with the school (i.e., counselor, administration) to collaborate about less restrictive accommodations to assist the student with school attendance prior to considering home instruction? Check Below: **_____ YES _____ NO** **If yes, describe below what the outcome was (i.e., modified day, private signal to leave the classroom to manage symptoms, point person such as the school counselor as needed, etc.)? Explain below why this is not sufficient.**

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Given the assumed high level of need based upon the home instruction request, what is your treatment plan recommended to the student/family? Include the facility name, type of facility (Psychiatric Hospitalization, Partial Hospital Program, Intensive Outpatient Program, Performcare/Children's Mobile/Bergen's Promise Program, Private Outpatient Therapy), and the start date, along with frequency, if applicable. (i.e., Private Outpatient Therapy 2-3 times per week...)
☐ Psychiatric Hospitalization: _____Facility Name/Start Date ☐ Partial Hospital Program (PHP): _____Facility Name/Start Date ☐ Intensive Outpatient Program (IOP): _____Facility Name/Start Date ☐ Child's Mobile/Bergen's Promise Program: _____Program/Start Date ☐ Private Outpatient Therapy: (ie, 2-3 times per week during this time of crisis): _____Provider/Start Date
What is the transition plan for the student to return to school? (i.e., the student can return to school with no restrictions on [date]; The student is recommended to return on [date] starting with a modified schedule/day; The student is set up with therapy and medication management will need a point person/counselor as needed; Recommended accommodations for the school environment; Excuse latenesses for the first two weeks...)

Requested start date of Home Instruction:	
Requested end date of Home Instruction:	

Section 4: Certification By Mental Health Provider	
Date of Evaluation:	
Signature of Provider:	

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The below is to be completed by the District Physician.

I have reviewed the report of the attending physician and **concur** OR **do not concur** with the determination that the student is eligible for home instruction.

Section 5: District Physician Approval	
Determination by District Physician	☐ Concur (Approved) ☐ Do Not Concur (Not Approved)
Date:	
Signature of District Physician:	