

Home or Hospital Instruction Application

My child is unable to attend school and I am requesting: _____ Home _____ Hospital (check one)

Student Name: _____ Birthdate: _____

Address: _____ Phone: _____

School: _____ Grade: _____ Date last attended: _____

I acknowledge that if I accept the instructional services, I agree to maintain the following conditions:

- ❖ Presence of an adult age 21 or older in the public location during the tutoring session.
- ❖ Presence of my child for all scheduled sessions
- ❖ Notify the homebound instructor in advance of any scheduled session if instructional time must be cancelled at least 24 hours in advance
- ❖ Monitoring completion of homework as well as other assignments
- ❖ Providing an updated application and physician statement bimonthly

Parent Signature: _____ Date: _____

*Complete and return this portion along with the Physician Statement to your student's building *
EC/ELEMENTARY- Assistant Principal

JUNIOR HIGH- Grade Level Counselor

HIGH SCHOOL- Dean of Intervention

TO BE COMPLETED BY SCHOOL PERSONNEL

Student ID# _____

Student's Classes/Services:

Teacher/Service Provider:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current IEP/504 on file _____ Yes _____ No

Related Services provided _____ Yes _____ No

Date: _____ Administrator Signature: _____

*After form is completed in its entirety, please return to Student Services/PSAC, Attn: Director of Student Services.

HOME/ HOSPITAL PHYSICIAN'S CERTIFICATION

TO BE COMPLETED BY A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL OF ITS BRANCHES, A LICENSED PHYSICIAN ASSISTANT, OR A LICENSED ADVANCED PRACTICE REGISTERED NURSE

Student Name: _____

Date of Birth: _____

DIAGNOSIS (Please complete the following)

Diagnosis/Injury/Surgery (Primary Diagnosis): _____ Other _____

(Describe): _____

If the diagnosis is a disease, is this disease communicable? _____ Yes _____ No

If yes, please provide instructions to school staff in the space below labeled "Special Recommendation to Teachers."

I, _____, certify that this student is unable to attend public school. I also certify that this student is medically and physically eligible to be enrolled in the following program:

Check one only _____ Home Instruction _____ Hospital Instruction

IMPACT THE DIAGNOSIS HAS ON THE STUDENT'S ABILITY TO ATTEND SCHOOL:

SPECIAL RECOMMENDATIONS TO TEACHER (e.g. diet, rest, exercise, positioning):

This physician must estimate that the student will require home or hospital instruction for a minimum of 10 school days this school year; the time may be longer than 10 days. Estimate the length of time the student will need Home/Hospital instruction (in weeks.) _____

Print Name of Physician

Physician Contact Telephone Number

Original Signature of Physician

Date

For School District Use Only: Date Home/Hospital Instruction began: _____ INITIALED _____