



Application for Home/Hospital Instruction

Section I

To be completed by the parent(s)/guardian(s)

School District _____ School _____ Grade _____

County of Residence _____ Last Date Attended _____

Name of Student _____ Date of Birth _____

Address of Student _____ Zip Code _____

Sex_Race _____ Social Security # _____ Telephone # _____

Full Name of Father/Guardian _____ Telephone# _____

Full Name of Mother/Guardian _____ Telephone# _____

Does the student have an Individualized Education Program (IEP)? Yes _____ No _____

Does the student have a Section 504 Plan? Yes _____ No _____

Directions to student's home _____

Pursuant to KRS 158.033(4), eligibility for home or hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) and shall be provided pursuant to the Individualized Education Program (IEP). The ARC chairperson shall provide written notice of home/hospital placement to the local Director of Pupil Personnel (DPP) for purposes of program enrollment using the form in section IV of this application. 702 KAR 7:150.

Pursuant to KRS 159.030(2), before granting any student an exemption from compulsory attendance, the board of education of the district in which the student resides shall require submission to the board of satisfactory evidence in the form of a signed statement of a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the child, stating that the diagnosed condition of the child prevents or renders inadvisable attendance at school and requires home or hospital instruction. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. On the basis of such evidence, the local board of education may exempt the student from compulsory attendance.

A student with a recurring condition, which results in periods in which the need for home or hospital instruction is intermittent and the student is able to attend school for short periods, may be exited and reentered on home or hospital instruction, and the following shall apply:

- (a) Initial approval by the Review Committee shall be required;
- (b) The Review Committee shall review the need for an alternative schedule of services based on verification by the professional statement in the application for home or hospital instruction of the need for intermittent services;

- (c) If a health professional who completed the initial application for a student to be served on home or hospital determines the student needs additional time for services, the health professional shall submit a written statement, either mailed or faxed, to the Director of Pupil Personnel, requesting additional time up to two (2) weeks for services and provide a brief explanation for the extension;
- (d) The Review Committee shall meet to review this extension and either approve or deny the request for an extension, prior to provision of any extended services;
- (e) The Review Committee shall review intermittent placement at least every six (6) months, and at that time a statement from a second professional, shall be required by the Review Committee for continued program eligibility; and
- (f) The parent or guardian shall notify the principal or Director of Pupil Personnel prior to the need for school reentry or to exit to home or hospital instruction.

Pregnancy is not considered a physical or health impairment in and of itself, and the nature and extent of any complication shall be delineated prior to consideration of home or hospital instruction for this condition. 702 KAR 7:150.

For students receiving home or hospital instruction pursuant to a determination by a Home or Hospital Review Committee, eligibility shall cease if the student works, plays sports or participates in extracurricular activities. 702 KAR 7:150.

RELEASE OF INFORMATION

I understand that if the Home/Hospital Review Committee makes the determination of placement for this student, they may request a review of the information provided on these forms by local health personnel. I hereby authorize this committee to have access to pertinent information regarding this request. I understand that if the Admissions and Release Committee makes the determination of placement for this student, they will have access to all pertinent information regarding this request.

Parent/Guardian/DCBS Worker
Signature

Date

Section I continued

Parent Agreement for Home/Hospital Instruction

1. A responsible adult must be present in the home/hospital room during the time the Home/Hospital Teacher is present.
2. The Home/Hospital Teacher meets with the student a maximum of two hours per week for individualized instruction. Absences are unexcused unless pre-arranged and the time rescheduled with the Home/Hospital Teacher during that same week.
3. A student with a communicable disease, as verified by a health professional, shall be eligible for the Home/Hospital Instruction Program. However, should the student's condition pose a serious health threat to the Home/Hospital Teacher, the student may receive alternate instruction such as correspondence, computer-assisted instruction, or video during the period of contagion.
4. Please check with your child regarding completion of required daily assignments in order to be ready for instruction at the next designated time.
5. Please provide a suitable work-study area where student and teacher can work with no interruption (for example: CD, tape player, and TV turned off). The area should be clean, neat, and free from household traffic.
6. Other children, visitors, or pets should be kept out of the room so that the teacher will have the student's full attention.
7. Arrange for the child to have sufficient rest and to be ready for work when the teacher arrives at the home.
8. Complete the Application for Home/Hospital Instruction, including release of medical information to school officials.
9. In addition to the scheduled weekly home/hospital instruction, the student will work independently to complete assignments.
10. Home/Hospital Instruction shall cease if a student works or participates in athletic activities.

I agree to abide by the above requirements and grant permission for this child to receive home/hospital instruction.

.....
Student Name

.....
Parent/Guardian/DCBS Worker Signature

.....
Date

PULASKI COUNTY SCHOOLS
Untraceable Electronic Communication
Parent Consent Form
2025-2026



Purpose

In compliance with Kentucky Senate Bill 181 (2025), this form allows a parent or legal guardian to give written permission for their child to communicate electronically with a specific school district staff member—such as an employee, coach, or volunteer—outside of the district’s approved traceable communication systems. Under this law, all school district staff/volunteers must use communication platforms designated by the local board of education for any electronic interaction with students. However, an exception is allowed if a parent or guardian provides written consent for a specific individual to communicate with their child using other methods.

Student Information

Student Name: _____ Grade Level: _____ School: _____

District Staff/Volunteer Information

Staff/Volunteer Name: _____ Team or Program: _____

Rationale: Why do the student and staff/volunteer need to use an untraceable communication system?

Parent/Guardian Information

Parent Name (print): _____ Relationship to Student: _____

Email Address: _____ Phone Number: _____

Parent/Guardian Consent

I, the undersigned parent/legal guardian of the student named above, hereby grant permission for the district staff/volunteer to communicate electronically with my child outside of the school district’s traceable communication systems. I understand and acknowledge that:

1. This communication may occur via personal platforms (e.g., text messaging, personal email, messaging apps).
2. The school district cannot access or monitor these communications.
3. This consent is valid for the current academic year only and must be renewed annually.
4. I may revoke this consent at any time by notifying the school and the district staff/volunteer in writing.
5. I do not authorize the district staff/volunteer to engage in inappropriate electronic communications with my child.
6. This signed form should be submitted to the *designated school district employee or volunteer*.

Parent/Guardian (signature): _____ Date: _____

Staff/Volunteer Agreement

Any electronic communication with a student outside of the traceable communication system shall comply with all terms of this written consent.

Staff/Volunteer (signature): _____ Date: _____

Processing Instructions

Parent/Guardian: Return this form to the person you identified as *Designated School District Employee or Volunteer*.

Staff/Volunteer: Submit this form to the employee responsible for the extracurricular program identified in this form.

Extracurricular Program Sponsor: Submit this form to your principal or administrative designee.

For Admin Use Only

Received by (signature): _____ Date: _____

**Application for Home/Hospital Instruction
Professional Statement**

***Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP). The ARC chair shall provide written notice of eligibility to the local Director of Pupils Personnel (DPP) for purposes of program enrollment. The form provided in Section IV shall be used to provide this notice. ***

Section II

This section is to be filled out by a properly licensed physician, advanced practice registered nurse, physician's assistant, psychologist, or psychiatrist responsible for diagnosing and treating the student. If the condition is mental health related, then the signed statement shall be completed by a licensed physician, psychiatrist, psychologist, or physician's assistant described in KRS 202A.011 or an advanced practice registered nurse defined in KRS 314.011 and certified in psychiatric-mental health nursing. In order for a district board of education to exempt a student from compulsory attendance, the student must provide satisfactory evidence in the form of a signed statement from a qualified healthcare professional that the diagnosed condition of the student prevents or renders inadvisable attendance at school and requires home or hospital instruction.

Name of Student _____

_____ I do/ ___ I do not support home/hospital instruction for this student. If you do not support home/hospital instruction at this time, please state your concerns and/or recommendations: _____

Please check one of the following:

_____ The student can attend school without any type of modifications or special provisions.
Comments: _____

_____ The student can attend school only with modifications or special provisions.
Describe Modifications Needed: _____

_____ The student is unable to attend school at this time due to health concerns, and I do support Home/Hospital instruction. **If checked, please complete the rest of Section II.**

Diagnosis _____ Prognosis: Good _____ Fair _____ Poor _____

Specific reason (s) why the student is unable to attend school at this time: _____

How long have you been seeing the patient for the diagnosis listed? _____

Approximate length of time student will need Home/Hospital Instruction _____

Recommended start date of Home/Hospital instruction: _____

Please summarize test and all other data collected that supports the need for Home/Hospital Instruction at this time.

What is the treatment plan for the patient? _____

What is the expected duration of treatment? _____

Start date of hospital admission, if applicable: _____

Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year. _____

What ancillary services are involved in treatment? _____

List consultants/specialist to whom this student has been referred.

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____

Will you be following the patient? _____ Yes_No. If not, who will? _____

Name _____ Telephone # _____

Address _____

Anticipated date of student's return to school _____

What are your recommendations to assist this student in their return to school? _____

Remarks/Comments: _____

Signature of Licensed Professional

Title

Date

Please Print or Type Name of Professional: _____

Office Address _____ Phone Number _____

Fax Number _____