Ms. Andrea Kersten
Superintendent of Schools

Request for Out of School Instruction Due to Medical or Emotional Disability

STUDENT NAME ____

DATE OF BIRTH ____________SCHOOL____________________GRADE _______

Home instruction provides only 10 hours per week of instruction for elementary children and only 15 hours per week for secondary students, compared to approximately 35 hours per week of a normal school program. Home instruction is not a program. Prolonged home instruction is insufficient for a child to learn effectively, to socialize, to complete necessary labs and physical education requirements, or ultimately to graduate. Home instruction is a short term measure for acute medical or emotional concerns for a period no longer than 10 weeks (one school quarter). In almost every case, the best place for a child is in school with peers. Accordingly, we make every effort to work with you to tailor a program that will suit the child's medical and/or emotional needs. Each school has a nurse to assist the child's need for rest or treatment based on your written order. All requests for home tutoring due to emotional issues must incorporate a re-entry plan with your request. The same is required for medical concerns if the child will need a gradual re-entry.

NOTE FOR EMOTIONAL DISABILITY: We do not provide tutoring in the home for a diagnosis of school avoidance, refusal, or phobia except for a period of adjusting medication, hospitalization or intensive therapy. In-home instruction is offered only if the student is confined to home. A school case manager is assigned for all children with emotional concerns to ensure a smooth team process for the child's successful return to the best program possible working with your student's private mental health provider. We ask you or your designate to work with the school's case manager on a regular basis to aid in the successful reintegration of the child back into the school program for all emotionally based problems.

***IMPORTANT NOTE: ALL REQUESTS GREATER THAN 2 WEEKS MUST INCLUDE A RE-ENTRY PLAN. A REQUEST IS GOOD FOR A MAXIMUM OF ONE QUARTER (10 WEEKS). Request will not be honored if form is not complete in its entirety. For an emotional disability, requests <u>will not be honored</u> if completed by anyone other than the treating <u>NYS Licensed Psychiatrist or NYS Clinical Psychologist</u> for an emotional condition. This may cause a delay in services.**

Diagnosis: *(please be specific and attach statement as necessary)*___________________________________

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____

47 Bloomingdale Avenue, Akron, NY 14001
Phone: 716-542-5006 Fax: 716-542-5018

Prognosis: *(please be specific and attach statement as necessary)* ____

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Is patient confined to home □ Yes □ No (If yes, please provide reason)
Reason:____

For Medical Requests: Is Patient <u>under on-going care</u> of a specialist? □ YES □NO

Name of specialist ____________________________________**Next visit**__________

For Emotional Requests: Is Patient <u>in active mental health therapy</u>? □ YES □ NO
If yes, next visit____
Child Psychiatrist: ____________________________________Phone :____________
NYS Licensed Clinical Psychologist________________________ Phone:____________
Other counselor*____ Phone___________

Is **Patient on medication** for current medical condition? □ **YES** □ **NO**

If ***yes*,** is the dosage and medication □**STABLE,** □**IN TRANSITION**? **If in transition**, please estimate how long it may take to stabilize this aspect of treatment: _____________ **Provide rationale for program modification request:**__________________________

____

Student:____**DOB:**______

ALL REQUESTS FOR OUT OF SCHOOL INSTRUCTION REQUIRE A RE-ENTRY PLAN

Requested Start Date *(student physically & mentally capable of learning)*:___________

Estimate End Date:_____________ □ No re-entry plan needed. Able to return full time
□ Needs re-entry plan as detailed below

RE-ENTRY PLAN REQUIRED:

A. TYPE OF INSTRUCTION *(please specify location; include a time-table, e.g. 1-week for each)*:

□ In-home, duration:_____________(Note: student must be confined to home for this option)

□ In public setting, such as public library, duration:___________________________

□ In school or tutoring center, but apart from regular classes, duration: _________

B. RE-ENTRY PLAN (combine with part A as part of a re-entry plan, or write your re-entry plan

□ Reduced day _____ hours *(Normal school day is 6 hours please specify 1-6)*
□ Delayed start *(please specify)* ____:____ AM /____:____PM
□ Early dismissal *(please specify)* ____:____ AM / ____:____PM
□ Planned rests in the health office *(please specify times)* ___________________
□ Evaluate for in-school support/tutoring with gradual return to regular classes

C. SPECIAL ACCOMMODATIONS IN SCHOOL

□ Extra passing time
□ Avoid passing time and large group settings (eg cafeteria, auditorium)
□ Early dismissal from class so student has safe passage in the hallways
□ Adult guidance from room-to-room
□ Elevator key □ wheelchair □ other assistive device______________________
□ Assistance with toileting
□ Please consider Committee on Special Education evaluation
□ OTHER ____

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____

Signature MD, DO, Ph.D., PsyD **Specialty or title** **Date**

Name: ____ NYS License #__________

Address : ____Phone:_________________

____

TO BE COMPLETED BY DISTRICT

_______ Additional medical information is necessary

_______ Consent to speak with doctor is necessary

Approval by District:

____
Authorized District Representative Date

47 Bloomingdale Avenue, Akron, NY 14001
Phone: 716-542-5006 Fax: 716-542-5018

Akron Central School District
Student Support Office
47 Bloomingdale Ave.
Akron, New York 14001
(716) 542-5035 FAX: (716) 542-5058
http://www.akronschools.org

RELEASE AND EXCHANGE OF INFORMATION FORM

Name: ____________________________ DOB: ______________ Grade: ____________________

Address: ____ Phone Number: _____________

Dear Parents/Guardians: We are committed to protecting the privacy of you and your child. In order to properly serve your child's needs as a public school district, we are required to obtain any necessary information. This form provides your authorization and helps us to provide appropriate educational services and/or coordinate with outside agencies to meet the needs of your child. This disclosure is also made at the request of you, the parent/guardian.

Who will disclose, use, and/or receive the information?

Akron Central School District
47 Bloomingdale Ave.
Akron, NY 14001

Phone : **(716)542-5035**

Fax : **(716)542-5058**

(As authorized by New York Education Law and/or the Individuals with Disabilities Education Act)

Organization: ______________________________

Address: ______________________________

____

Phone: ______________________________

Fax: ______________________________

<u>What information will be used or disclosed?</u> The appropriate boxes should be checked below so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used.

The following information:

- ☐ Psychological reports
- ☐ Educational evaluations
- ☐ Speech evaluations
- ☐ Physical therapy evaluations
- ☐ Health/Medical records
- ☐ Social work records
- ☐ Occupational therapy evaluations
- ☐ Current IEP's
- ☐ Academic Records
- ☐ Observations
- ☐ Other:

SPECIFIC UNDERSTANDINGS: By signing this authorization form, you authorize the use or disclosure of your child's protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

You have a right to refuse to sign this authorization. Your child's right to attend public school will not be affected if you do not sign this form. You have a right to see and copy the information described on this authorization form in accordance with district policies.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the service provider has already taken action based upon your authorization. To revoke this authorization, please write to the Akron Central School District, Director of Student Services, 47 Bloomingdale Ave., Akron, NY 14001.

SIGNATURE: *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

________________________________ ________________________________ __________
Signature of Parent or Guardian of Student Print Name of Parent or Guardian of Student Date

________________________________ ________________________________ __________
Signature of Student (If age 18+) Print Name of Student Date

THE PARENT OR GUARDIAN MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.