SCSD REQUEST FOR MEDICAL HOME INSTRUCTION

This applies to students with a medical absence of five consecutive school days (full) or more, or for absences extending to ten full school days over a three-month period. This form must be completed in its entirety to be considered. Approved tutoring will typically commence 2-3 days following approval and hours cannot be deferred.

Parent: Please sign this form, bring it to your child's medical provider and return the fully completed form to your child's school counselor or school administration. If approved for tutoring, tutors will contact you directly to schedule appointments. An adult must be present in the home for in-person instruction. Eligible tutoring hours cannot be deferred for future use.

Student_____Grade _____ School_____

Parent/Guardian_____Phone No. _____

email: _____

Home Address_____

My child's medical provider has been notified that he/she has my permission to discuss this case with the Somers Schools' Physician, and/or other school authorities.

_____ _____

Parent's/Guardian's Signature Date

Medically excused dates of absence from school: _____

If exact dates are unknown, please contact your student's school. The above information must be accurate and included in advance of completion by your medical care professional.

Student's Medical Care Professional: This is to certify that I have examined the above-identified child, and as a result of my findings, conclude that the student is/was medically unable to attend school on the above dates noted due to the following condition:

Diagnosis:_____

Prognosis:_____

Reason why student's condition prohibits school attendance/special notes:_____

_____

For long term absences, monthly medical updates regarding the progress of treatment are requested.

_____

Medical Professional's Name (Stamp) Date Examined Phone Number

_____ _____

Signature **Return date (known or estimated)**

Eligible number of hours per day for home instruction: **Grades 1-5: 2 hrs. Grades 6-12: 3 hrs.**

Approved: ☐ **Not Approved**: ☐ _____

Director of School Counseling & Student Support (initials/date) **cc: Nurse**