APPLICATION FOR HOMEBOUND INSTRUCTION

MUST BE COMPLETED ANNUALLY

ALL MEDICAL DOCUMENTATION MUST BE FOR CURRENT SCHOOL YEAR INCLUDING 504 PLANS

Homebound Instruction shall be made available to enrolled students who are confined at home or in a health care facility for periods that would prevent normal school attendance (8VAC20-131-180). The term "confined at home or in a health care facility" means the student is unable to participate in the normal day-to-day activities typically expected during school attendance; and, periods away from home are infrequent, and for relatively short duration, or to receive health care treatment. Students receiving homebound instruction may not work or participate in extra- curricular activities, non-academic activities (such as field trips) or community activities unless these activities are specifically outlined in the students' medical plan of care, 504 Plan or the Individualized Education Program (if applicable). Homebound Instruction is temporary, based on the premise that instruction should take place in the school setting to the fullest extent possible. The intent is to return the student to their home school as soon as possible.

To be completed by the licensed physician, licensed clinical psychologist or nurse practitioner providing care to the student for the condition for which services are requested.

1. Name of Student: _____ DOB: _____
2. School: _____ Sex: _____ Age:_____ Grade: _____
3. Nature and extent of illness: _____
   _____
   _____
4. Date of examination or diagnosis of this illness: _____
   If pregnant, due date: _____
5. Is the student confined at home or in health care facility? ____Yes ____No
6. Is the illness/treatment intermittent in nature (e.g. sickle cell anemia, chemotherapy for childhood cancer)? ____Yes ____ No If yes, please describe on an attached sheet.
7. Could this child attend school if accommodations are made by the school? _____Yes ____ No
   If yes, please list the accommodations required. If no, please explain. _____
   _____
   _____
8. Estimated date of return to school: _____
9. If the estimated date of return to school is longer than nine weeks, please attach a detailed transition plan to return the student to their home school, including expected date of re-entry.
10. Explain ongoing treatment and/or therapy being provided: _____
    _____
    _____
11. Frequency of treatment: _____

PLEASE NOTE: THIS STUDENT COULD BE TRUANT OR UNDER A COURT ORDER TO ATTEND SCHOOL. YOU AND THE STUDENT'S MEDICAL RECORDS ARE SUBJECT TO SUBPENA BY THE COURT IN SUCH CIRCUMSTANCES.

_____ _____

Signature of Physician/ Psychologist/ Nurse Practitioner Date

_____ _____

Print Physician/ Psychologist / Nurse Practitioner Name Telephone Number/ Fax Number

_____

Office Address: Street City, State and Zip Code

(OVER)

Student may receive instruction in the home, health care facility, or other approved location as agreed upon by the school division and parent or student who has reached the majority (eligible student).

To be completed by the parent/guardian or eligible student.

Name of Parent/Guardian or eligible student: _____
Home phone: _____ Cell phone: _____Work phone: _____
Street address: _____
City: _____ State: _____ Zip code: _____

Acknowledgement/ Release: I acknowledge this request and agree with the need for homebound services. I further acknowledge that the requested homebound services for students receiving special education services shall be subject to review by the student's IEP team pursuant to the Individuals with Disabilities Education Act. I will provide an environment conducive to learning, ensure that a responsible adult is in the home for the duration of instruction, or provide transportation to another agreed upon facility. I will keep appointments with the homebound teacher or contact the teacher or homebound office if an appointment must be missed.

I understand that the Hampton City School division has established policies and procedures for homebound instruction that provide more detail that this certificate of need.

By my signature, I authorize the release and exchange of medical information between the health care provider listed on the reverse side, or his/her designee, and school division personnel. My signature provides the health care provider (s) with authorization necessary to disclose protected health information and records regarding said student as it pertains to the condition for which homebound instructional services are being requested. My signature provides school personnel with authorization necessary to disclose FERPA protected education records and information to the health care provider. This authorization may be withdrawn at anytime in writing.

Please note: This form, including parental permission to contact the treating health care provider must be fully completed in order for the student to be considered for homebound services.

If you have questions about completing this form, please contact the Homebound office at 727-2152.

_____ _____
Signature of Parent/Guardian or Eligible Student Date

SCHOOL:

The school _____does _____ does not recommend homebound placement for this student.

Additional Information: _____

_____

School site designee signature: _____ Date: _____

(Revised February 2016)