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Application for Home/Hospital Instruction

Section I **2020-2021**

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

School District ______________________ School ___________________________

Grade ________ County of Residence _____________________________________

Last Date Attended ______________ Special Education Student _____ Yes _____ No

Name of Student __________________________________ Date of Birth ________

Address of Student ____

Sex ____Race ____ Social Security #__________________ Telephone # ___________

Full Name of Father/Guardian _____________________Work Phone ____________

Full Name of Mother/Guardian _____________________ Work Phone ____________

Parent/Guardian Email ____

List any Special Education Programs in which your son or daughter may be enrolled:

____

Directions to Student's Home ____

____

Pursuant to KRS 159.030, Board of Education shall require satisfactory evidence, in the form of a signed statement by a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor or public health officer, that the condition of the child prevents or renders inadvisable attendance at school. On the basis of such evidence the Board may exempt the child from compulsory attendance. Any child who is excused from school attendance more than six (6) months must have two (2) signed statements from two different health personnel which can be a combination of the following professional persons: a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor and/or health officer. Exemptions of all children must be reviewed annually with the evidence required being updated. If a medical professional certifies that a student has a chronic physical condition unlikely to substantially improve within one (1) year, then the one-signed statement is sufficient for services that extend beyond six (6) months. This exception does not apply to students with mental health conditions.

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). In lieu of this application the ARC chairperson shall provide written notice of this eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment. Children with disabilities certified by a medical professional to have a chronic physical condition unlikely to substantially improve within three (3) years may continue to be eligible for home/hospital instruction services, based on the admissions and release committee's (ARC) annual review of documentation to determine if updated evidence is required. Updated documentation of evidence of need for home/hospital services for children with chronic physical conditions shall be provided as requested by the ARC, or at least every three (3) years.

RELEASE OF INFORMATION

I understand that the Home/Hospital Review Committee 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.

______________________________ ______________________

Parent/Guardian Signature Date

Section I continued

Parent Agreement for Home/Hospital Instruction

1. A responsible adult must be present in the home/hospital room or designated area during the time the Home/Hospital teacher is present if circumstances allow face to face instruction. Otherwise, all instruction will be virtual, video or correspondence.
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 with the home/hospital instructor and the time rescheduled during that same week.
3. Please check with your child regarding completion of required daily assignments in order to be ready for instruction at the next designated time.
4. Please provide a suitable work-study area for instruction with no interruption (for example: TV and external stimuli turned off). The area should be clean, neat and free from household traffic.
5. Other children, visitors or pets should be kept out of the room when instruction is being given from a home/hospital instructor whether face to face or virtually to minimize distractions.
6. Arrange for the child to have sufficient rest and to be ready for work when the teacher is scheduled for instruction time.
7. Complete the application for Home/Hospital instruction, including release of medical information to school officials.
8. In addition to the scheduled weekly home/hospital instruction, the student will work independently to complete assignments.
9. Home/Hospital instruction and eligibility shall cease if a student works or participates in athletic activities.
10. The Home/Hospital committee will review each application received for Home/Hospital instruction. If daily virtual instruction as offered by the school district is deemed more appropriate and beneficial for instruction, a Home/Hospital application can be denied.

I agree to abide by the above requirements and grant permission for this child to receive home/hospital instruction as deemed appropriate by the Home/Hospital Review Committee.

____

Student Name

____ __________________

Parent Guardian Signature Date

Professional Statement

PROFESSIONAL STATEMENT MUST BE FILLED OUT COMPLETELY

Section II

To be completed by the authorized health professional.

Home Instruction (homebound) is short-term instruction provided in a home or other designated site for a student who is temporarily unable to attend school. It shall be determined that a child or youth is to be provided home/hospital instruction if the condition of the child or youth prevents or renders inadvisable attendance at school as verified by signed professional statement in accordance with KRS 159.030 (2) and 704 KAR 7:120. According to state guidelines, two hours of home instruction each week is the equivalent to one full week of school attendance. Home instruction is not designed to take the place of a more appropriate school placement.

Home Hospital applications for mental health reasons will only be considered if completed by a licensed psychologist or psychiatrist. Pursuant to 704 KAR 7:120, the condition of pregnancy is not to be 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/hospital instruction for this condition.

Name of Student ____

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 you do support home/hospital instruction at this time, please fill out 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 ______________________

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

____

What is the treatment plan for the patient ____

____

____

Section II continued

What is the expected duration of treatment ____

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

What ancillary services are involved in treatment ____

____

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

Name	Specialty	Phone
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________

Will you be following the patient? _____ Yes _____ No If not, who will?

Name ______________________________ Phone Number ____________________

Address ____

Anticipated date of student's return to school ____

What are your recommendations to assist this student in his/her return to school ____________________

____

____

Remarks/Comments ____

____

____

____

______________________________	____________________	____________________
Signature of Authorized Professional	Title	Date

Please Print or Type Name of Professional ____

Office Address ______________________________ Phone Number ____________________

______________________________ Fax Number ____________________

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