HAMPTON City Schools

Extended Services

Adult and Alternative Learning Center
1646 BRIARFIELD ROAD
Hampton, Virginia 23669

P: (757) 727-2152 F: (757) 268-3306

APPLICATION FOR *INTERMITTENT HOMEBOUND* INSTRUCTION

MUST BE COMPLETED ANNUALLY

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

Some students have chronic illnesses that may 'flare up' necessitating short, frequent periods of time away from school. For these students, it is appropriate for the physician or licensed clinical psychologist to request intermittent homebound services. These are services that would start and stop based on pre-defined triggers. Examples of students who may require intermittent homebound services are those with cancer, while they are receiving chemotherapy or are immune suppressed; or, children with sickle cell disease who are in 'crisis.' The homebound instructional services for these students should be individualized to minimize the interruption of instruction. The parent is to provide a note to the school when the student is absent due to the illness reported on this form. If absences become excessive, school personnel will contact the medical provider to advise.

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: _____
5. Could the student's condition require full time homebound at any time? _____Yes _____ No
   If yes, please describe the number of absences that would require contact from the school.
   _____
   _____
   _____
6. Explain ongoing treatment and/or therapy being provided: _____
   _____
   _____
7. 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 Intermittent homebound for this student.

Additional Information: _____

_____

School site designee signature: _____ Date: _____

(Revised August 2018)