UNIONVILLE-CHADDS FORD SCHOOL DISTRICT
APPLICATION FOR HOMEBOUND INSTRUCTION
PHYSICIAN'S STATEMENT

Unionville-Chadds Ford School District believes that students must attend school if they are physically and psychologically able to do so in order to maximize their educational, social, developmental, and extra-curricular opportunities.

Authorization for release of health information:
I request that my child be provided homebound instruction services. I authorize appropriate school personnel to contact my child's physician/psychiatrist/psychologist listed on this form for information related to this request at any time during the period that services are required. I understand the District's right to gather sufficient information to support this request.

This information will be maintained in accordance with the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA)

Signature of parent/guardian _____ Date _____

In order for a student to receive homebound service, he/she must be medically/psychologically unable to attend school for a minimum of ten consecutive days. The information that you provide will be reviewed by the principal and the supervisor of homebound instruction for the School District to determine the extent of homebound services that will be approved.

Student _____ Date of Birth _____ Grade _____ School _____

Parent/Guardian _____

Street Address _____ City _____ State/Zip Code _____

Date of initial examination _____ Date confinement begins _____ Estimated date confinement ends _____

Dates that student will be confined in a hospital From _____ To _____

Dates that student will be confined at home From _____ To _____

Diagnosis (including a description of the disabling condition)
_____

_____

_____

Prognosis
_____

_____

_____

Describe the proposed treatment plan including the schedule of follow-up appointments
_____

_____

_____

It is the mission of the Unionville-Chadds Ford School District to create a caring environment that gives all students the opportunity to achieve their fullest personal and academic potential in order to become productive and responsible citizens.

Will the student be taking any medications that would have an effect on his/her ability to comprehend instructions, complete independent assignments, or work with the homebound instructor for a minimum of one hour per session? If so, please explain how this may affect homebound instruction.

Explain why the student is unable to receive instruction in the regular school setting.

Are there any reasonable accommodations that would make it possible for your patient to attend school? YES NO

Please describe those accommodations or if not possible, explain why there are no reasonable accommodations.

What is the transitional plan for the student to return to school?

Will the student be able to attend school on a partial schedule before returning full time? YES NO

If yes, what is the maximum number of hours that the student could attend daily? _____

Is the student able to maintain a job outside of the home? YES NO

If yes, what is the maximum number of hours that the student can work? _____

Is the above named student able to participate in extra-curricular activities without any restriction? YES NO

PHYSICIAN'S CERTIFICATION:

I understand that homebound instruction is intended to provide short-term tutoring (5 hours per week for a maximum of three months) and cannot replace or duplicate school-based instruction. I understand that I may call school personnel and that school personnel may contact me to gather or share additional information related to this request for homebound instruction. Furthermore, I understand that homebound instruction may be terminated if the student fails to comply with the prescribed treatment. I certify that this student is under my care and treatment for the aforementioned illness/disability. My recommendation has been based on the medical needs of the patient, keeping in mind that the least restrictive educational environment is preferred.

Name of physician (printed) _____ Area of specialty _____

Signature of physician _____ Date _____

Physician's street address _____ City/State/Zip _____

Phone _____ FAX _____

Date that recommendation is submitted to School District _____