UPDATE FORM FOR CONTINUED HOMEBOUND INSTRUCTION

This form is only to be used to request an extension on existing approved Homebound Instruction.
To apply for Homebound Instruction, please reach out to your student's School Social Worker, Counselor, or School Nurse.

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Student ID #: _____

TO BE COMPLETED BY PROVIDER: ***(PhD and MSW will need to be co-signed by a physician).***
Your patient has applied for Homebound Instruction, a temporary program for students with **severe medical or psychological conditions**. It provides limited instruction during treatment and is not a substitute for classroom learning; students may not gain the same knowledge or earn enough credits to graduate. Please be certain your patient requires this service before you complete this form. An annual physical exam must be attached to this application.

Medical Diagnosis: _____

_____

Surgical Procedure(s): _____

Psychological/Psychiatric Counseling: _____ **required for mental health diagnosis*

Medication(s): _____

Current Status/Disposition of Patient: _____

Anticipated End Date: _____ Last Office Visit: _____

How frequently do you see the patient? _____

Briefly describe treatment plan: _____

_____

Why is your patient unable to have instruction in a regular classroom? _____

_____

Can any reasonable accommodation be made to keep your patient in the classroom? *Please explain.*

☐ Yes, _____

☐ No, _____

Thank you for your time. Please provide medical updates every 90 days as requested. **Please have parent/guardian sign the attached medical release of information for your office. Please forward a copy with this application.**

Provider's Signature: _____ Date: _____

Address: _____

Phone Number: _____ Fax: _____

Provider's Stamp (Preferred) or Print Name: _____

725 Harrison St, Syracuse NY 13210 | T: (315) 435-4145 | F: (315) 435-4859 | HealthServices@SCSD.us | syracusecityschools.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Parent/Guardian: Please complete and sign this document so that we may get health information from your student's doctor.

Student Name: _____ DOB: _____ Date: _____

As the parent/guardian of the student named, the completion of this form authorizes your doctor to disclose your student's confidential health-related information to their school.
The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the student's school. This is important information for many reasons. For example, the school may need to know this information to give medications, monitor the student's illness, and keep track of immunizations.

Provider/Practice Name: _____

Address: _____ Phone Number: _____

This authorization limits the disclosure of information to the following:

- Immunization information
- Physical exam reports
- Laboratory tests
- Medications and treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.
The information will be disclosed to the school in the school district indicated below until you tell us that the child is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the child's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the child's information to their school. The child's healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your child treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. Please keep a copy for your records.

_____ _____
Student's Name (print) Date of Birth

_____ _____
Parent/Guardian's Name (print) Relationship

_____ _____
Parent/Guardian's Signature School

725 Harrison St, Syracuse NY 13210 | T: (315) 435-4145 | F: (315) 435-4859 | HealthServices@SCSD.us | syracusecityschools.com

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Student ID #: _____

CURRENT PROGRAM:

☐ Homebound
☐ Operation School
☐ Hospital School

SCHOOL DISTRICT: TO BE COMPLETED BY MEDICAL DIRECTOR OR DESIGNEE

☐ 90-Day Extension Approved

Comments: _____

_____

☐ 90-Day Extension Denied

Reason: _____

_____

Signature: _____ Date: _____
Medical Director or Designee

FOR STUDENT SUPPORT SERVICES DEPARTMENT USE:

Instruction will begin/began on _____

Homebound or Operation School Teacher _____

Hours/Week of instruction: _____ Date Assignment Closed: _____

Disposition of case:
☐ Returned to School
☐ Re-entry Plan
☐ 504 Plan
☐ School Meeting

Signature: _____ Date: _____
Student Support Director or Designee

725 Harrison St, Syracuse NY 13210 | T: (315) 435-4145 | F: (315) 435-4859 | HealthServices@SCSD.us | syracusecityschools.com