APPLICATION FOR HOMEBOUND INSTRUCTION OR OPERATION SCHOOL

You have requested that your child participate in the Syracuse City School District Homebound Instructional Program. The program is designed for students with **severe temporary medical or psychological problems or conditions which prevent them from attending school** to provide some instruction while the student is under treatment. The instruction is provided by certified teachers who come to the student's house or another meeting place. High School, Middle School, and Special Education students receive Homebound Instruction for 2 hours/day for 10 hours/week. Elementary students receive homebound instruction for 1 hour/day for 5 hours/week. It is **not** a substitute for the classroom. Students are not able to obtain the knowledge in homebound instruction that they would get at school. They may not have enough classes or credits to graduate.

The following is required to apply for Homebound or Operation School Instruction:

1. Homebound or Operation School Application.
2. Medical or Psychological Evaluation and completion of application by a physician, describing the medical condition, diagnosis and reason(s) why student is unable to attend school.
3. Homebound due to pregnancy form to be completed by physician, NP or Nurse-Midwife.
4. Reviews and updates as determined necessary by the District.
5. All homebound instruction will **expire after 90 days**. **Any request for homebound instruction exceeding 180 days must be evaluated by the District's Section 504 committee.**
6. Operation School must be renewed annually.
7. An up to date (within 12 months) physical exam.
8. A medical release of information is attached (page 6) and must be completed.
9. Please submit the Homebound/Operation School application to Health Services as notated at the bottom of this page.
10. The Medical Director may request additional information from the student's physician. Incomplete applications will be returned and will delay the start of homebound instruction. The need for homebound instruction shall be based upon the determination of the Medical Director.

APPLICATION FOR HOMEBOUND OR OPERATION SCHOOL

All medical records must be received prior to approval.

HOMEBOUND

Homebound is reserved ONLY for the following conditions when they prevent a student from being able to attend school:

a) Major surgical operations
b) Major orthopedic conditions
c) Medical catastrophes
d) Pregnancy (after delivery of baby or if there are complications)
e) Psychiatric conditions **(with on-going treatment plan)**

All cases of Homebound will be reviewed after 90 days for on–going treatment. Homebound requests lasting more than 180 days must be evaluated through the Section 504 Committee. Please attach as much medical information as possible to support your application in case your child meets criteria for other programs.

OPERATION SCHOOL

Operation School is reserved ONLY for the following conditions when they prevent a student from being able to attend school:

a) Sickle cell disease
b) Cancer
c) Severe respiratory disability (must document hospitalization and lung capacity evaluation by your physician)
d) Chronic medical conditions requiring frequent hospitalizations, appointments (at discretion of Medical Director)

To Medical Providers:

Please note that if a student has been hospitalized, the parent or guardian must provide a release from you for the student to return to school. Parents/guardians must bring in the discharge instructions/papers from the hospital with the diagnoses and any instructions or orders for the nurses.

If you are keeping a student out of gym, or if the student has medical restrictions, please send a note stating how long this will be in effect; otherwise, we will need a full release from you at a later date.

HOMEBOUND/OPERATION SCHOOL APPLICATION

Student's Name: _____ DOB:_____

School: _____ Grade: _____ Student ID #: _____

Date of application: _____

Parent/Guardian Name: _____

Mailing Address: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Emergency Contact and Phone Number: _____

Primary Doctor's Name _____

Address: _____

Phone Number: _____

TO BE COMPLETED BY PARENT OR GUARDIAN:

Are you requesting ☐Homebound Instruction, ☐Operation School, or ☐Hospital School?

Why do you feel Homebound, or Operation School will help your child? _____

_____

How long do you think your child will be receiving homebound if approved? Remember Homebound is temporary and must be **renewed every 90 days**. _____

I understand that Homebound or Operation School Instruction is not a substitute for the classroom
☐ Yes ☐ No Initials _____

I understand that Homebound Instruction will expire every **90** days.
☐ Yes ☐ No Initials _____

I understand that I need to **provide a medical or psychological update every 90 days**. I will not be reminded; failure to do so will result in termination of homebound and I will need to reapply.
☐ Yes ☐ No Initials _____

Does your child have an IEP or a 504 Plan? ☐ IEP ☐ 504 Plan ☐ No

I have obtained and attached a copy of my child's physical exam. ☐ Yes ☐ No Initials _____
APPLICATION WILL NOT BE REVIEWED IF YOU DO NOT HAVE A COPY OF THE PHYSICAL EXAM.

Parent/Guardian Signature: _____

Print Name: _____

Date: _____

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Student ID #: _____

HOMEBOUND FOR PSYCHOLOGICAL CONDITIONS: *To be completed by parent/guardian*

If your child has an IEP or 504, please notify Special Education and a meeting will be held to discuss the concerns.

1. Describe previous attempts to bring your child into a regular classroom. _____

   _____

2. Does your child meet special needs criteria? ☐ Yes ☐ No
   If no, have you tried to have your child tested? ☐ Yes ☐ No

3. Have you discussed your child with your principal or School Intervention Team (SIT) to determine if your child can be reasonably accommodated? ☐ Yes ☐ No

   Explain: _____

   _____

4. What medication(s) is your child on for his/her condition? _____

   _____

5. How long have they been on these medications? _____

HOMEBOUND FOR PREGNANCY: *To be completed by physician, NP or nurse-midwife*

Estimated date of delivery: _____

Date homebound is to begin: _____

Anticipated End Date: _____

District policy states that homebound instruction will not begin until 2 weeks prior to delivery date unless there are serious complications.

Describe complications: _____

Can any reasonable accommodations be made to keep your patient in the classroom?
☐ Yes, _____
☐ No, _____

Date homebound is to begin due to complications: _____

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. The program is designed for students with **severe temporary medical or psychological problems or conditions** to provide some instruction while the student is under treatment. This is **not** a substitute for the classroom. Students are not able to obtain the knowledge in homebound instruction that they would get at school. They may not have enough classes or credits to graduate. Please be certain your patient requires homebound instruction before you complete this form. An annual physical exam (within the past year) must be attached to this application.

Medical Diagnoses: _____

Surgical Procedure(s): _____

Medication(s): _____

Current status/disposition of patient: _____

Anticipated end date: _____

Last office visit: _____

How frequently do you see the patient? _____

Briefly describe treatment plan: _____

Parents are required to provide medical updates every 90 days for homebound, yearly for Operation School.

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

_____

Can any reasonable accommodations be made to keep your patient in the classroom?

☐ Yes, _____

☐ No, _____

Thank you for your time. Please provide medical updates every 90 days as requested. **PLEASE SEE INSTRUCTIONS ON PAGE 2 FOR WHEN STUDENT RETURNS TO SCHOOL. Please have parent/guardian sign the attached medical release of information for your office. Please forward a copy with this application.**

Date: _____

Provider's Signature: _____

Provider's Stamp - Required: _____

Address: _____

Phone Number: _____

Fax: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child's doctor.

Student Name: _____DOB: _____ Date: _____

As the parent/guardian of the child named, the completion of this form authorizes your doctor, _____ to disclose your child's confidential health-related information to his or her school.
(Name of Doctor)

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 child's school. This is important information for many reasons. For example, the school may need to know this information in order to give medications, monitor the child's illness, and keep track of immunizations.

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.

Child's Name (print)	Date of Birth
Parent/Guardian's Name (print)	Relationship
Parent/Guardian's Signature	School

Please return to School Nurse

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Student ID #: _____

SCHOOL DISTRICT: TO BE COMPLETED BY MEDICAL DIRECTOR OR DESIGNEE

☐ Approved
- ☐ Homebound
- ☐ Operation School
- ☐ Hospital School

☐ Not Approved
- ☐ Missing physical exam
- ☐ Missing other information _____
- ☐ Missing doctor's notes
- ☐ Missing medical release form
- ☐ The mental health professionals in the school district will work with the student to strengthen coping skills and the ability to interact with other students.
- ☐ Other _____

Signature (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
- ☐ School Meeting

Signature (Student Support Director or designee): _____