#117-AR Form A
Hbinstructionpkt (yellow)

EAST STROUDSBURG AREA SCHOOL DISTRICT
HOMEBOUND INSTRUCTION REQUEST

BASIC INFORMATION

Person Making Request _____ Date of Request ____/____/____

Student's Name _____ Birthdate ____/____/____

School _____ Grade _____ Homeroom _____

Home Address _____ Telephone _____

_____ School Counselor _____

Parent(s)/Guardian(s) _____ Physician(s) _____

The **School Counselor** will release the East Stroudsburg Area School District *Application for Homebound Instruction* form (No. 117-AR Form B) to the parent(s)/guardian(s). The parent(s)/guardian(s) must complete his/her/their portion of the form and is/are responsible for obtaining the physician's signature and approval.

Type of homebound requested: ☐ Physical ☐ Mental

Date request and application forms released to parent(s)/guardian(s) ____/____/____

Date/completed forms received by guidance counselor ____/____/____

ACKNOWLEDGMENT OF HOMEBOUND REQUEST & RECOMMENDATIONS

In accordance with guidelines set forth in the applicable administrative guidelines and procedures, this confidential form should be routed to those of the following four (4) individuals deemed applicable for their review, signature and, as is appropriate, recommendations.

Nurse

_____
Name
____/____/____ ____/____/____
Date Received Date Forwarded

School Counselor

_____
Name
____/____/____ ____/____/____
Date Received Date Forwarded

If student is Special Ed., please complete the following information: NOREP Date ____/____/____
IEP Date ____/____/____
ER/RR Date ____/____/____

Assistant Superintendent for Pupil Services

_____ Approve *_____ Disapprove

_____
Name
____/____/____ ____/____/____
Date Received Date Forwarded

Building Administrator

_____ Approve *_____ Disapprove

_____
Name
____/____/____ ____/____/____
Date Received Date Forwarded

Recommendation if Disapproved:** _____ ***ESASD Cyber Academy or _____ ***Return to Home Bldg.***

Date Asst. Supt. for Pupil Services Contacted Parent w/Recommendation ____/____/____

Following the return of the completed application form, signed by parent(s)/guardian(s), physician(s), and school personnel, the guidance counselor will forward the completed request and application forms to the Office of Pupil Services as indicated in the administrative guidelines and procedures.

Date Forms sent to Office of Pupil Services ____/____/____ Sent By: _____

Date Form sent from the Office of Pupil Services to the respective school's Main Office ____/____/____
Sent by: _____

ACTION

A. Notification of approval of homebound instruction received from the Office of Pupil Services.

Date ____/____/____ Received By: _____

B. Homebound instructor(s) employed for instruction:

Date Secured: ____/____/____ Employee: _____

Date Secured: ____/____/____ Employee: _____

C. Conference between homebound instructor(s) and classroom teacher(s) arranged:

Date: ____/____/____ Facilitator: _____

D. Schedule(s) of homebound instruction supplied to principal's office by homebound instructor(s).

Date: ____/____/____ Received By: _____

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RE-EVALUATION

As per the recommendation of the physician(s) on the *Application for Homebound Instruction* form, a **maximum** of three (3) months after homebound instruction has begun, the Assistant Superintendent will conduct a re-evaluation to determine whether homebound instruction should continue. Subsequent re-evaluations must occur at a maximum of three (3) month intervals should the student's period of homebound instruction be extended.

____/____/____ ____/____/____
Date Instruction Began Re-Evaluation Date

Re-Evaluation Conducted by: _____ ____/____/____
Name(s) Date

Determination: _____

SUBSEQUENT RE-EVALUATION

____/____/____ ____/____/____
Date of Last Re-evaluation Re-evaluation Date

#117 – AR Form B
Hbinstructionpkt (blue)

EAST STROUDSBURG AREA SCHOOL DISTRICT
APPLICATION FOR HOMEBOUND INSTRUCTION
(Please type or print where appropriate)

I hereby apply for homebound instruction for my son/daughter _____ / / - -
Student's Name Grade Date of Birth

who is now unable to attend school per the recommendation of the below-signed physician.

School _____

_____ Address _____
Signature of Parent(s)/Guardian's

_____

Telephone Number _____ Date of Request ____/____/____

****

PHYSICIAN'S STATEMENT

Date of Last Examination ____/____/____

I find the above-named student to have the following disability: **(PLEASE TYPE OR PRINT)**

Diagnosis: _____

Description of Symptoms: _____

_____

Prognosis: _____

What prevents this student from attending school? _____

Do you recommend homebound instruction for this student? _____ Yes _____ No

Approximate length of time student will be on homebound _____ Weeks or _____ Months [Maximum 3 months]
(Please be advised that if a re-evaluation for homebound instruction is requested, at maximum, in three (3) month intervals. An extension to the initial three (3) month period, must be approved by PDE before continuing).

Indicate number of hours recommended for instruction per week _____ [maximum allowed is 5 hours)

Date ____/____/____ _____
Physician's Signature

Physician's Address:

_____ _____
Please Type or Print Physician's Name

_____

_____
Physician's Telephone Number

_____/____/____ _____ _____
Signature of the Superintendent of Schools Date Approved Disapproved

Please Note: **Homebound Instruction will not be approved if a student will be absent from school for less than ten (10) consecutive school days, unless extenuating circumstances warrant otherwise.**

9/21/2018 12:46 PM REVISED

EAST STROUDSBURG AREA SCHOOL DISTRICT
East Stroudsburg, Pennsylvania 18301
Health Services Department
Release of Information

Date of Request ____/____/____

We request that _____ at
(Primary Care Provider, Agency, School)

_____
(Street Address)

_____
(City) (State) (Zip)

release the records indicated below of:

_____ ____/____/____ _____ _____
(Student's Name) (Birth Date) (School Year) (Grade)

_____ Permanent School Health Record
_____ Summary of Most Recent Examination (Diagnosis, Precautions, Restrictions, Prognosis, Limitations, Next Scheduled Appointment)
_____ Hospital Discharge Summary
_____ Diagnostic Test Results (Specify) _____
_____ Complete Enclosed Forms:
_____Medical Authorization
_____Specialized Health Procedure/Treatment Order
_____Adaptive Physical Education
_____Health Care Plan Data
_____Vision
_____Hearing
_____Scoliosis
_____Homebound
_____*Second Opinion Requested by E.S. School District (NOTE: Per Board Policy #117 – the "school district reserves the right to seek a second opinion by a certified physician, certified psychiatrist and/or certified psychologist of the school district's choice")

_____ Other (Please Specify): _____

_____

Please send records to: _____
(School Nurse)

East Stroudsburg Area School District
(School/Agency)

50 Vine Street
(Street)

East Stroudsburg PA 18301
(City) (State) (Zip)

_____ _____
(Signature of Parent/Guardian) (Date)