



School	Contact	Phone	Fax
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HOME INSTRUCTION APPLICATION & SERVICES PLAN

I. STUDENT INFORMATION			
a. Check one: <input type="checkbox"/> Student with an IEP <input type="checkbox"/> Non-disabled Student		b. Case Manager: _____ Ext. _____	
c. Date of Application: _____ <input type="checkbox"/> Initial <input type="checkbox"/> Extension (circle one)		#1	#2 #3
d. Check Type of Application: <input type="checkbox"/> Medical <input type="checkbox"/> Re-evaluation <input type="checkbox"/> Suspension/Expulsion <input type="checkbox"/> Other (explain): _____			
e. Name of Student: _____		f. DOB: _____	g. School: _____ h. Grade: _____
i. Parent/Guardian: _____			
j. Address: _____		City: _____	State: NJ Zip: _____
k. Home Phone: () _____		Cell: () _____	Work: () _____
II. CONSENT FOR RELEASE OF INFORMATION			
I authorize the release of medical, educational, or mental health information to school officials.			
_____ Signature of Parent/Legal Guardian/Surrogate Parent/Student (age 18+)		_____ Date	
III. MEDICAL INFORMATION (To be completed by physician)			
Completion of this form with physician's signature certifies the need for home instruction, due to the conditions listed below. Please complete (as specifically as possible) the diagnosis, symptoms, and prognosis including limits in place for this student. <i>Note: Washington Township Public School will not provide home instruction until the physician's recommendation for home instruction has been verified by the school doctor. The student named above is being treated by me and will need home instruction.</i>			
a. Does condition prevent student from maintaining school schedule?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Medical or psychological diagnosis: If pregnant, please indicate due date: _____			
c. Is this a chronic health condition that may require intermittent services?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Symptoms: _____			
e. Prognosis: _____			
f. Recommendations and explanations of diagnosis (<i>Note: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into the regular school environment as soon as possible.</i>): _____			
g. Number of weeks student will require HI services: _____ weeks		Date of hospitalization: _____	
h. Anticipated date student will return to school (tentative): <u>mm/dd/yy</u> <i>Note: Written doctor's release required for student to return to school.</i>			
Physician must sign and date below. _____ Signature _____ Date _____ Fax #: _____		Physician's stamp must be affixed in this area. _____	
Indicate area of Licensed Speciality: <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Neurologist			
Parent permission to implement services plan: _____ Date _____			

STUDENT NAME: _____

DOB: _____

IV. SCHOOL NURSE USE ONLY

a. _____ Date recommendation received	b. _____ Date verification received	c. _____ Nurse's signature
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V. WTPS PHYSICIAN CONFIRMATION ONLY

Note: This form must be reviewed and returned to the school nurse (via fax or school courier) within three (3) days.

- I have reviewed this application and I approve the provision of homebound instruction services.
- I have reviewed this application and I **do not** approve the provision of home instruction services.

Rationale for denial of services: _____

Signature of Dr. Theodore Koerner _____ Date _____

VI. COUNSELOR/TEACHER USE ONLY

Teacher: Please indicate on the chart below, your interest (or non-interest*) and return this form to Counseling before the end of the school day.

*If **NOT INTERESTED**, please submit an outline of all assignments to be completed; include instructional materials (textbooks, workbooks, worksheets, etc.) for the assigned tutor to utilize during the home instruction time period. All materials must be submitted to the **COUNSELING OFFICE**, as soon as possible. Your cooperation will expedite the home instruction process and is greatly appreciated.

	<u>Teacher Name</u>	<u>Instructional Area</u>	<u>Time Period Requested</u>	<u>Interested</u>	<u>NOT Interested</u>	<u>Instructor/ Service Provider</u>
1	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
5	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
6	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
7	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
8	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
9	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

VII. ADMINISTRATIVE USE ONLY

Home Instruction Service Plan Approved:

Principal _____ Date _____ Director of District School Counseling _____ Date _____

VIII. RETURN TO SCHOOL

The above named student has been determine medically able to return to school and may return on _____.
(Doctor's release must be given to school nurse). Return Date

School Nurse's Signature Date

The school nurse must notify the student's School Counselor of the return to school date. In addition, a copy of this form must be sent to the Director of District School Counseling.