## WASHINGTON TOWNSHIP PUBLIC SCHOOLS Department of Student & Special Education Services 206 East Holly Avenue Sewell, NJ 08080

Phone: (856) 589-6644 Fax: (856) 589-3718

## **HOMEBOUND APPLICATION & SERVICES PLAN**

I. STUDENT INFORMATION									
a. Check one: Student with an IEP Non-d	isabled Student	b. C	ase Manager:		Ext				
c. Date of Application: mm/dd/yy	Initial	Extensi	on (circle one)	#1	#2 #3				
d. Check Type of Application: Medical Reevaluation Suspension/Expulsion Other (explain):									
e. Name of Student:	f. DOB: m	nm/dd/yyyy	g. School:		h. Grad	de:			
i. Parent/Guardian:	<b>"</b>				•				
j. Address:	City:			State: NJ	Zip:				
k. Home Phone: ( )	Cell: ( )			Work: ( )	•				
II. CONSENT FOR RELEASE OF INFORMATION									
I authorize the release of medical, educational, of	or mental healt	th informatio	n to school off	icials.					
Signature of Parent/Legal Guardian/Surrogate Parent/Legal Guar	arent/Student	(age 18+)		Date					
III MEDICAL INFORMATION (To be a second at a decombronic in a									
III. MEDICAL INFORMATION (To be completed by physician)									
Completion of this form with physician's signature certifies the need for homebound 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. NOTE: Washington Township Public School will not provide homebound instruction until the physician's									
recommendation for homebound instruction has been verified by the school doctor. The student named above is being									
treated by me and will need homebound instruction.									
a. Does condition prevent student from maintain	ning school sc	hedule?	Yes	☐ No	)				
b. Medical or psychological diagnosis:									
If pregnant, please indicate due date:									
c. Is this a chronic health condition that may red	quire intermitt	ent services?	Yes	∐ No	)				
d. Symptoms:									
e. Prognosis:									
f. Recommendations and explanations of diagnosis ( <u>NOTE</u> : In the case of emotional disorders, a treatment plan should be									
designed to encourage the re-entry of the stu	dent into the r	egular schoo	l environment	as soon as po	ssible.):				
g. Number of weeks student will require HBI se	ervices:	weeks	Date of h	ospitalization	:				
h. Anticipated date student will return to school	<u> </u>	mm/dd/yy							
Note: Written doctor's release required for student	· ·								
Physician must sign and date below.			stamp must be	affixed in thi	s area.				
		•	•						
Signature	Date								
Fax #:									
Indicate area of Licensed Speciality:	.D.	D.O.	Psychiatris	st N	eurologist				
Parent permission to implement services plan: _				Date					

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STUDENT NAME:			DOB: _	DOB:					
IV. SCHOOL NURSE USE ONLY									
		IV. SCHOOL N	IUKSE USE UN	LT					
a		b		C					
Date recommendation	on received	Date verificatio	n received	Nurse's signatu	are				
V. WTPS PHYSICIAN CONFIRMATION ONLY									
Note: This form must be	e reviewed and retui	rned to the school r	nurse (via fax or	school courier) wit	hin three (3) days.				
I have reviewed this the provision of hom		•		• • •	tion and I <b>do not</b> approve I instruction services.				
Rationale for denial of services:									
			<u> </u>						
Signature of Dr. Theodo		/I. GUIDANCE/	TEACHER USE O	Date					
Teacher: Please indicate on the chart below, your interest (or non-interest*) and return this form to Guidance 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 GUIDANCE OFFICE, as soon as possible. Your cooperation will expedite the home instruction process and is greatly appreciated.  Teacher Instructional Time Period NOT Instructor/									
<u>Name</u>	<u>Area</u>	<u>Requested</u>	Interested	<u>Interested</u>	Service Provider				
1				H -					
3		-		<u> </u>					
4 5				H -					
6				<u> </u>					
7 8				H -					
9				<u> </u>					
		VII. ADMINIST	RATIVE USE ON	IV					
Homebound Service Pla		VIII. ADIVINAISTI	NATIVE OSE OIL						
Principal	Dat	re	Assis	tant Superintenden	t 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 g		•	to return to scri	oor and may return	Return Date				
	School Nurse's Signature				Date				
The school nurse must	notify the student's	: Guidance Counse	lor of the retu	rn to school date	In addition, a conv of this				

form must be sent to the Assistant Superintendent for Student and Special Education Services.