BUENA REGIONAL SCHOOL DISTRICT

P.O. BOX 309
BUENA NJ 08310

HOMEBOUND INSTRUCTION APPLICATION & SERVICES PLAN

SECTION I. STUDENT INFORMATION	
Name of Student:	DOB: / /
School:	Grade:
Parent/Guardian:	
Address:	City:
Home Phone:	Cell Phone:
Reason for Request for Home Instruction:	
Individual Making Request:	Date of Request:

SECTION II. CONSENT FOR RELEASE OF INFORMATION

I authorize the release of medical, educational, and/or mental health information and records for my child,

_____, to/from school officials to/from the medical provider

identified herein.

_____ _____

Signature of Parent/Guardian/ Student (18+) Date

SECTION III. MEDICAL INFORMATION
(To be completed by physician if applicable)

Physician certification/signature is required for all medically-based home instruction requests to receive full consideration. The requesting physician must be appropriately certified to diagnose and/or treat the child's condition that presents the need for home instruction. No requests due to medical reasons will be approved without physician certification/signature. For requests due to social/emotional and/or behavioral reasons, the district may require this form to be completed by an appropriately licensed/certified mental health provider. Students may only return to school when cleared to do so in writing by the requesting physician. Requests for Home Instruction due to medical reasons, if approved, will only be granted for 30 days and must include a plan outlining steps to transition the student back to school.

Does the condition prevent the student from maintaining a school schedule? ____ Yes ____ No

Please describe: _____
_____
_____
_____
_____

Medical or psychological diagnosis:
If pregnant, please indicate due date:

Is this a chronic health condition that may require intermittent services? ____ Yes _____ No

Recommendations and explanations of medical condition and re-entry to school plan: _____
_____
_____
_____
_____
_____
_____
_____
_____

Requested length of Home Instruction Services (max of 30 days for medical reasons): _____ days

Anticipated date student will return to school (tentative): / /
(Note: Written note from physician is required for student to return to school)

_____
Physician's Signature Date

Fax #:

Physician's stamp must be affixed to this area

SECTION IV. PARENTAL AUTHORIZATION/CONSENT

I give my permission to implement the Home Instruction.

_____ _____

Parent/Guardian/ Adult Student Signature Date

SECTION V. BUENA ADMINISTRATIVE USE ONLY

Request Approved: _____ _____

Principal Signature Date

_____ _____

Director of Special Education Date

Request Denied: _____ _____

Principal Signature Date

_____ _____

Director of Special Education Date

SECTION VI. BUENA SCHOOL PHYSICIAN CONFIRMATION ONLY

Note: This form must be received and returned to the Director of Special Education within three (3) days.

_____ I have reviewed this application and I **approve** the provision for Homebound Instruction Services.

_____ I have reviewed this application and I **do not approve** the provision for Homebound Instruction Services.

Rationale for denial of services: _____

_____

_____

_____

_____

_____

_____ _____

School Physician Signature Date

SECTION VII. BRSD USE ONLY

The student is entitled to _____ hours per week of Home Instruction.

Instructional Area	Teacher	Number of Hours per week
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____