

REQUEST FOR HOMEBOUND INSTRUCTION

Student Name: _____ Grade: _____
Address: _____ Birthdate: _____
School: _____ Homeroom Teacher: _____
Person Reporting Case: _____

*****CERTIFICATION BY PHYSICIAN*****

The Williamsport Area School District cannot determine whether a student's condition prevents him or her from attending classes. The District must rely upon a physician to make this determination. When it is necessary for a student to be absent for two weeks or more, homebound instruction may enable educational progress to continue while the student is recovering and receiving treatment. Pennsylvania Department of Education regulations require medical certification. Homebound certification may not exceed three (3) months. ***Continuation beyond three months requires an updated physician's certification and Pennsylvania Department of Education approval.*** If approval is not granted, alternative educational arrangements or a return to school is necessary. A release of information (attached) is necessary to allow for clarification of questions between the physician and the district.

- Access to homebound instruction is contingent on the availability of a suitable instructor.
- Not all courses can be presented in a homebound setting. Core courses only (Eng/Sci/Math/SS).
- A maximum of 5 hours instruction per week will be provided.
- Instruction will only be provided during the regular school year and not over summer or holidays.
- A condition requiring homebound instruction assumes that the student is incapable of employment or participation in extracurricular activities unless specifically required by the physician as part of a treatment plan.

If there are any questions regarding this form, please call Student Services at 327-5500, ext. 40000.

HOMEBOUND INSTRUCTION CANNOT BE APPROVED UNLESS THERE IS A SPECIFIC RETURN TO SCHOOL DATE WITHIN 3 MONTHS INDICIATED BY THE PHYSICIAN/PSYCHIATRIST.

Diagnosis: _____

Date Homebound Eligibility Begins: _____ Return to School Date: _____

Signature of Attending Physician/Psychiatrist

Date

Print name of Attending Physician/Psychiatrist

Phone number of Physician/Psychiatrist

****CERTIFICATION BY SCHOOL OFFICIAL****

Homebound instruction is approved for (Student Name) _____

Homebound Instruction for the above student will be for a maximum of 5 hours per week for the school year. Instruction is approved from _____ and end by _____ during the _____ school year.

The teachers are as follows:

TEACHER	SUBJECT	HOURS PER WEEK

Date: _____

Approved by: _____

Dr. Richard Poole – Director of Student Services

WILLIAMSPORT AREA SCHOOL DISTRICT
Release of Confidential Information

Re: Student's Name _____ DOB _____
Address _____ Building _____
_____ SID# _____

I hereby authorize **Williamsport Area School District** to:

Release to: _____ or Secure from: _____

(School District, Agency, or Individual)

the following information:

Dates of Service or Treatment _____

Psychological/Psychiatric Reports
 Neurological Reports
 Family Background Information
 Special Work Reports
 Aptitude or Achievement Scores
 School Health Records
 Vocational Skills Assessment

Medical Reports
 Progress Notes
 Report Cards
 Attendance Data
 Discharge Summaries
 Teacher Observations
 Other (Specify) _____

Note: My evaluation or diagnosis and /or treatment may be released as indicated by my initials next to the information to be released.

This information is needed for the following purpose (s):

_____ to aid in the coordination of services that address the child's/family's needs.

_____ other (specify) _____

Please send the requested information to the following address:

All information presented will be held in strict confidence. This release will be considered valid for not more than one year beyond the date signed.

Effective Date: From: _____ To: _____

- This authorization may be revoked by written request at any time. Revocation will not affect action taken by the above prior to the date of revocation.
- The above named agencies and individuals may release only information they have generated and not information created by other agencies or institutions. Information from other agencies or institutions will require a separate release.

Signature of Student/Parent/Guardian/*Other

Date

If *Other, please specify relationship _____

Witness

Date

I have: received declined a copy of this release.