Henderson County Schools

Student Services
1805 Second Street, Henderson, Kentucky 42420
(270) 854-0141 Fax: (270) 831-5155

Application for Home Hospital Instructions:

1. **Parent/Guardian – complete pages 1 and 4**

2. **Doctor – complete pages 2 and 3**

3. **Once the application has been completed by both parties, please fax the entire application to (Student Services) at 270-831-5155.**

Section I: Parent/Student Information

To be completed by the parent (s) /guardian (s) prior to full completion by the licensed medical or mental health professional.

School District _____ School _____ Grade _____
County of Residence _____ Last Date Attended _____
Special Education Student _____ Yes _____ No

Name of Student _____ Date of Birth _____
Address of Student _____ Zip Code _____
Sex _____ Race _____ Social Security # _____ Telephone # _____
Full Name of Father/Guardian _____ Work Phone _____
Full Name of Mother/Guardian _____ Work Phone _____

List any special education programs in which your student may be enrolled:

List directions to student's home:

Pursuant to KRS 159.030, Section (2), before granting an exemption under paragraph (d) of subsection (1) of this section, the board of education shall require satisfactory evidence, in the form of a signed statement of a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor or public health officer, that the condition of the child prevents or renders inadvisable attendance at school or application to study. On the basis of such evidence the board may exempt the child from compulsory attendance. Eligibility for home/hospital instruction for students with disabilities shall be determined by the Admissions and Release Committee (ARC) in accordance with their Individual Education Program (IEP), with the services to be in the least restrictive environment. In lieu of this application, the ARC chairperson shall provide written notice of this eligibility to the local Director of Pupil Personnel (DPP) for purposes of program enrollment.

Any child who is excused from school attendance more than six (6) months must have two (2) signed statements from two different local health personnel which can be a combination of the following professional persons: a licensed physician, advanced registered nurse practitioner, psychologist, psychiatrist, chiropractor and health officer. If a medical professional certifies that a student has a chronic physical condition unlikely to substantially improve within one (1) year, then the one signed statement is sufficient for services that extend beyond six (6) months. This exception does not apply to students with mental health conditions.

Exemptions of all children under the provisions of subsection (1) (d) of this section must be reviewed annually with the evidence required being updated, except that children with disabilities certified by a medical professional to have a chronic physical condition unlikely to substantially improve within three (3) years may continue to be eligible for home/hospital instruction services, based on the admissions and release committee's (ARC) annual review of documentation to determine if updated evidence is required. Updated documentation of evidence of need for home/hospital services for children with chronic physical conditions shall be provided as requested by the ARC, or at least every three (3) years.

Pursuant to 704 KAR 7:120, the condition of pregnancy is not to be considered a physical or health impairment in and of itself, and the nature and extent of any complication shall be delineated prior to consideration of home/hospital instruction for this condition.

RELEASE OF INFORMATION

I understand that the Home/Hospital Review Committee may request a review of the information provided on these forms by local health personnel. I hereby authorize this committee to have access to pertinent information regarding this request.

_____ _____
Parent/Guardian Signature Date

Section II: Medical Professional Statement

This section is to be filled out by the authorized medical or mental health professional.

It shall be determined that a child or youth is to be provided home/hospital instruction if the condition of the child or youth prevents or renders inadvisable attendance at school as verified by signed professional statement in accordance with KRS 159.030 (2) and 704 KAR 7:120.

Please Note: *Home Instruction (homebound) is short-term instruction provided in a home or other designated site for a student who is temporarily unable to attend school. According to state guidelines, two hours of home instruction each week is the equivalent to one full week of school attendance. Home instruction is not designed to take the place of a more appropriate school placement.*

Name of Student _____

Please check **one** of the following:

Δ The student can attend school without any type of modifications or special provisions. Comments:

Δ The student can attend school only with modifications or special provisions. Describe modifications needed:

Δ I **do not** support home/hospital instruction at this time. Concerns and/or recommendations:

Δ The student is unable to attend school at this time due to health concerns and **I do** support Home/Hospital instruction
If you support home/hospital instruction at this time, please provide the following information:

Diagnosis _____

Prognosis ☐ Good ☐ Fair ☐ Poor

Specific reason (s) why the student is unable to attend school at this time:

How long have you been seeing the patient for the diagnosis listed?

Approximate length of time student will need Home/Hospital Instruction:

Please summarize test and all other data collected that supports the need for Home/Hospital instruction at this time:

What is the treatment plan for the patient?

What is the expected duration of treatment?

_____ Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year.

What ancillary services are involved in treatment?

List consultants/specialist to whom this student has been referred.

Name	Specialty	Phone

Will you be following the patient? ☐ Yes ☐ No If not, who will?

Name: _____ Phone Number: _____

Address: _____

Anticipated date of student's return to school: _____

What are your recommendations to assist this student in his/her return to school?

Additional Remarks/Comments:

_____

Signature of Licensed Professional Title Date

Please Print or Type Name of Professional:

*An application for mental health reasons may be considered if completed by a licensed psychologist or psychiatrist.

Office Address_____

Phone Number _____

Fax Number _____

Parent Agreement Letter for Home/Hospital Instruction

_____
Date

Dear Parent:

_____ a student at _____
Student's Name *Name of School*

has met the requirements for the Home/Hospital Instruction Program.

There are several ways in which you can assist us in continuing the education of your child during his/her illness:

1. A responsible adult must be present in the home/hospital room during the time the Home/Hospital Teacher is present.
2. The Home/Hospital Teacher meets with the student a minimum of one hour on two (2) school days per week for individualized instruction. Absences are unexcused unless pre-arranged and the time rescheduled with the Home/Hospital Teacher during that same week.
3. A student with a communicable disease, as verified by a health professional, shall be eligible for the Home/Hospital Instruction Program. However, should the student's condition pose a serious health threat to the Home/Hospital Teacher, the student may receive alternate instruction such as correspondence, computer-assisted instruction, or video during the period of contagion.
4. Please check with your child regarding completion of required daily assignments in order to be ready for instruction at the next designated time.
5. Please provide a suitable work-study area where student and teacher can work with no interruption (for example: CD, tape player, and TV turned off). The area should be clean, neat, and free from household traffic.
6. Other children, visitors, or pets should be kept out of the room so that the teacher will have the student's full attention.
7. Arrange for the child to have sufficient rest and to be ready for work when the teacher arrives at the home.
8. Complete the Application for Home/Hospital Instruction, including release of medical information to school officials.
9. In addition to the scheduled weekly home/hospital instruction, the student will work independently to complete assignments.

I agree to abide by the above requirements and grant permission for this child to receive home/hospital instruction.

_____ _____
Parent/Guardian's Signature ***Date***

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