HOMEBOUND REQUEST FOR STUDENTS

STUDENT BACKGROUND INFORMATION

Name of Student: _____ **Date of Birth:** _____

School: _____ **Grade Level:** _____

MEDICAL CERTIFICATION – TO BE COMPLETED BY HEALTH CARE PROVIDER OF STUDENT WITH DIAGNOSED MEDICAL CONDITION

A. Basis of Request for Home Instruction Services:

The above listed student is unable to attend school for (check one):

☐ **Two or more consecutive weeks based on the diagnosed medical condition listed below; or**

Estimated length of time this student will be unable to attend school (in weeks*): _____.

*If it is anticipated that the student will be unable to attend school for more than 12 weeks, the District will require a new request for home instruction form to be filled out every 12 weeks.

☐ **On an ongoing intermittent basis** based on the diagnosed medical condition listed below.**

**"Ongoing Intermittent Basis" means that the student's medical condition is of such a nature or severity that it is anticipated that the student will be absent from school due to the medical condition for periods of at least two days at a time multiple times during the school year totaling at least 10 days or more of absences.

B. Diagnosed Medical Condition Causing this Student to be Unable to Attend School: _____ Date of Original Diagnosis: _____

C. Rationale for the Estimated Length of Time Indicated for Absence or Nature of Absence: _____

_____

D. Impact the Diagnosed Medical Condition has on this Student's Ability to Attend School: _____

_____

E. Impact the Diagnosed Medical Condition has on this Student's Ability to Participate in Home Instruction: _____

_____

F. Any Additional Relevant Information on the Diagnosed Medical Condition to Support Educational Programming: _____

_____

_____ _____

Print Name of Health Care Provider Date

_____ _____

Signature of Health Care Provider Phone Number of Health Care Provider

ACKNOWLEDGEMENT & AGREEMENT FORM – TO BE COMPLETED BY PARENT/GUARDIAN OF STUDENT WITH DIAGNOSED MEDICAL CONDITION

I, Parent/Guardian of the above-named student, agree and acknowledge the following if my student is approved for home instruction:

- My student may not have access to the full selection of instructional programming offered at school;
- My student's serving school, teacher, and/or service providers may be altered in light of my student's placement in home instruction;
- My student is not eligible to participate in or attend extracurricular activities offered by the District; and
- Home instruction may involve use of third-party virtual platforms, and such creates potential privacy risks, such as risks related to encryption reliability, unauthorized access, data breaches and/or student access to non-school sponsored content.

_____ _____

Print Name of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Phone Number of Parent/Guardian

CONSENT FOR HEALTH CARE PROVIDER RELEASE – TO BE COMPLETED BY PARENT/GUARDIAN OF STUDENT WITH DIAGNOSED MEDICAL CONDITION

I, Parent/Guardian of the above-mentioned student, authorize the District and the Health Care Provider listed above to mutually exchange information, including records, written communications, and verbal communications, concerning my student's medical condition and the impact on my student's ability to attend school. This authorization is valid for one year unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the School District or the Health Care Provider in reliance upon my authorization and prior to notice of my revocation. I recognize that health records, once received by the School District, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the *Family Educational Rights and Privacy Act* and the *Illinois School Student Records Act*. I understand that if I refuse to sign this release authorizing disclosure of information, such refusal will not interfere with my student's right to obtain a free appropriate public education, however, it may impact the District's ability to obtain the necessary information to consider my request for home instruction for my student.

_____ _____

Print Name of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Phone Number of Parent/Guardian

***Parent/Guardian—Please return this completed form to dol@d181.org so the student's team may consider whether such home instruction services are medically necessary. If the student's parent/guardian disagrees with the team's decision relative to the home instruction request, the parent/guardian may contact the Superintendent.**