Received_____ **Status**_____

APPLICATION FOR APPROVAL OF HOMEBOUND/HOSPITAL INSTRUCTION – MUST BE SUBMITTED EACH SEMESTER – APPROVAL DOES NOT AUTOMATICALLY CARRY OVER

For students who cannot attend school due to a medical condition.
Students who can attend school part me do not qualify under this program.

SUBMIT TO:
Homebound Instruction Office
Roy J. Wasson Academic Campus
2115 Afton Way
Colorado Springs, CO 80909
Ph: (719) 328-3077 Fax: (719) 328-3071

Name of Student:_____School: _____

Home address:_____ Zip: _____ Grade: _____

Birthdate:_____Home Phone: _____ Cell/work Phone: _____

Email address: _____

Is the student receiving services for: □504? □ I.E.P.?

Please Print Parent Name_____***Signature of Parent/Guardian***_____

****This signature authorizes my physician/psychiatrist to share the information stated below with pertinent School District 11 staff members.***

STATEMENT OF PHYSICIAN OR PSYCHIATRIST: Probable length of time a child will be unable to attend school must be expected to be over intermittent absences totaling more than 10 full days of school.

Pregnancy: Approximate due date: _____ (Homebound instruction is **typically authorized after delivery.** If the physician believes that school attendance is inadvisable prior to delivery because of risk factors to the mother or baby, tutoring may be authorized). The pregnancy problem must be noted here: _____

Physician's/Psychiatrist's Brief Description of the Medical Problem: (Please state why the student is unable to attend school).____

> If the student's diagnosis is a communicable disease, include procedures to be followed by the homebound instructor who will be working with the student._____.

NOTE TO PHYSICIAN OR PSYCHIATRIST: ***This student will be receiving no more than 3-5 hours of instruction per week under the Homebound Instruction program.***

Calendar dates to be excused from school:_____ Calendar date to return to school:_____
(If the return date is not yet known, please record an approximate date and we will check back with you for an update)

_____ _____
Physician's or Psychiatrist's Name (*No nurse or PA signatures will be accepted) **Signature of Physician or Psychiatrist** (*No nurse or PA signatures)

Physician's/Psychiatrist's Address: _____Telephone: _____Date Signed:_____

*Homebound instruction can only be provided with a signature from a Colorado licensed physician or psychiatrist.
*No signatures will be accepted from nurses, nurse practitioners, psychologists, or physician assistants.
Incomplete information will be returned, and will delay services.

STATEMENT OF STAFFING COMMITTEE/ADMINISTRATOR (if other than a physical limitation)

Brief statement of the problem: _____

Note length of time to receive homebound instruction: _____

Committee, Supervisor, Administrator Signature:_____

FOR ADMINISTRATIVE USE

Name of homebound instructor: _____ **Phone:**_____ **Email**:_____

Date homebound was arranged: Date homebound ended: