HOSPITAL/HOMEBOUND APPLICATION PACKET

Purpose of Homebound Instruction

The purpose of hospital/homebound services in Grant Parish is to temporarily meet the needs of a student who is unable to attend school due to physical or emotional/mental problems. The goal of the program is to assist the student in maintaining his/her educational level and allow a smooth and timely return to the school setting. **Hospital/Homebound instruction is not the best educational setting for a student.** It is very demanding upon the student, and it is difficult for the student to keep up with missed class work.

Criteria for Acceptance:

1. The original application packet must be completed in its entirety including answers to all questions required of the referring physician, psychiatrist, or certified psychologist and returned to Denise Young at Grant Parish School Board Office by mail or by person. Faxed forms or copies will not be accepted. An original signature (not a stamp) is required of the referring party.

2. The student may not be employed while receiving hospital/homebound services nor may he/she attend after school functions such as dances, ballgames, club meetings, etc.

3. A student must not be recommended for expulsion and/or have an expulsion hearing pending unless determined by the parish superintendent of schools or a hearing officer.

4. A physical referral must be completed by a physician if the student is unable to attend school due to a physical illness or injury. The referring party, a school nurse, the school psychologist, and the SBLC committee will confer as needed regarding the student's condition. These people will make a decision regarding the student's need for homebound services.

5. An emotional/mental referral must be completed by a psychiatrist or licensed psychologist if the student is unable to attend school due to emotional/mental issues. The referring party, a school nurse, the school psychologist, and the SBLC committee will confer as needed regarding the student's condition. These people will make a decision regarding the student's need for homebound services. A student referred for mental/emotional reasons must be actively involved in a treatment program during homebound services. Failure to participate in a treatment program on a regular basis will result in denial of homebound services.

Please note:

1. If a student has been recommended for expulsion and/or has expulsion hearing pending, homebound services will not be considered until the superintendent has acted upon the recommendations of the expulsion committee.

2. If a student has excessive absences (not due to his/her homebound placement) which prevent a credit in a course, no credit for the course will be given. The homebound student will be instructed only in the areas where he/she is receiving high school credits.

3. An emotional/mental referral by a physician will not be accepted.

4. Pregnancy is not grounds for homebound services. If the student is pregnant, a medical evaluation must verify that there are complications in the pregnancy which could be detrimental to the student to be considered to qualify for services prior to delivery. Students are considered for homebound services 4-6 weeks after delivery. C-section patients are eligible for services up to 6 weeks after delivery.

5. If the student is accepted he/she will be eligible starting on the day the completed application is received by Mrs. Young at Grant Parish School Board Office. Incomplete forms will delay the process.

6. Once the application is processed, services will begin within 3 days. A homebound teacher will contact the parent/guardian by telephone.

7. The parent should check with the school for assignments until notified that the student has been accepted for homebound services.

8. All textbooks and material are to be picked up at the school by the parent/guardian prior to the first session.

9. A responsible adult, age 21 or older, must be present in the household during homebound sessions. The homebound teacher will not remain in the home if uncomfortable with the adult left in charge. It is best if the person is a parent or guardian.

10. This application will not be processed if the packet is missing required information.

I have read, understood, and accepted the guidelines of Grant Parish School System Hospital/Homebound services.

____________________________________ ________________________

Signature Parent/Guardian Date

STUDENT INFORMATION SHEET

<table>
<tr><td>Student Full Name:</td><td colspan="7"></td></tr>
<tr><td>School:</td><td></td><td>Grade:</td><td></td><td>Date of Birth:</td><td></td><td>Gender :</td><td></td></tr>
<tr><td>Parent/ Guardian Name:</td><td></td><td>Home Phone #:</td><td>(______) ____-_____</td><td>Work Phone #:</td><td>(______) ____-_____</td><td>Cell #:</td><td>(______) ____-_____</td></tr>
<tr><td>Street Address:</td><td></td><td>City:</td><td colspan="3"></td><td>Zip Code:</td><td></td></tr>
<tr><td>Directions to Home:</td><td colspan="7">______________________________
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Does the student have a current: Special Education Evaluation? ___________
Individualized Education Plan (IEP)? ___________
Behavior Management Plan (BMP)? ___________
Individualized Health Plan (IHP)? ___________
504 Plan? ___________

CONSENT TO RELEASE MEDICAL INFORMATION

Waiver of Confidentiality Form

All information that has been gathered on an individual is personal and private, and you are not required to release this information. Such information cannot be released without authorized written permission except as required by law.

I UNDERSTAND THAT THE INFORMATION OF:

Name of Student:		Date of Birth:
Address:		Phone:
City:	State:	Zip:

IS PERSONAL AND PRIVATE. HOWEVER, I GIVE PERMISSION FOR:

Name of Doctor:		
Address:		Phone:
City:	State:	Zip:

TO RELEASE TO:

Name: School Nurse, School Level Principal or his/her designee,
Denise Young, Grant Parish Supervisor of Special Education

Address: P.O. Box 208 Colfax, LA 71417 ___________

THE FOLLOWING INFORMATION -- MEDICAL RECORDS

______

( ) I UNDERSTAND THAT I HAVE A RIGHT TO DISCLOSE MY TESTS RESULTS.

( ) I DO NOT AUTHORIZE THE RELEASE OF MY TEST RESULTS.

THE MEDICAL RECORD OF THE PERSON LISTED ABOVE IS TO BE RELEASED FOR THE SPECIFIC PURPOSE OF:____

Comments or Other Information:____

____

____

I UNDERSTAND THAT MY PERMISSION TO RELEASE THIS INFORMATION MAY BE CANCELLED ANY TIME EXCEPT WHEN THE INFORMATION HAS ALREADY BEEN RELEASED. MY PERMISSION TO RELEASE THE INFORMATION WILL EXPIRE UPON WRITTEN NOTIFICATION TO THE SCHOOL NURSE AND DENISE YOUNG AT THE ABOVE ADDRESS.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PARENT/GUARDIAN OF THE PERSON LISTED ABOVE AND HAS THE LEGAL AUTHORIZATION TO SIGN ON BEHALF OF THE PERSON WHETHER BY COURT ORDER OR OPERATION OF LAW.

Signature of Parent/Guardian: ______________________________ Date: __________

HOSPITAL/HOMEBOUND REFERRAL FOR TEMPORARY PLACEMENT DUE TO EMOTIONAL/MENTAL ILLNESS

Doctors, before completing this form, please note:

1. Homebound services are temporary services to be requested only when a student absolutely cannot attend school.
2. It is very difficult for a student to keep up with schoolwork while receiving homebound services.
3. Registered nurses monitor student needs and medications at each school.

Section 1 – Student Information							
Student Name:		**Age:**		**Date of Birth:**		**Gender:**	
Parent/Guardian Name:		**Home Phone #:**	(______) ____-_____	**Work Phone #:**	(______) ____-_____	**Cell #:**	(______) ____-_____
Street Address:		**City:**				**Zip Code:**	

Section 2 – Mental/Emotional Certification

NOTE: This referral must be completed by a psychiatrist or licensed psychologist if the student is unable to attend school due to a mental illness, emotional crisis, or the treatment thereof. All questions must be answered and initialed by the psychiatrist or psychologist (where indicated) for the application to be processed.

1. Description of Mental/Emotional Condition / Diagnosis:	__________ __________ __________ __________ __________					
2. Is the student expected to be absent from school due to a mental/emotional condition for at least fifteen (15) school days?	**YES**		**NO**		**INITIALS**	
3. Is the student confined to the hospital or home?	**YES**		**NO**		**INITIALS**	
4. Will the student be able to participate in and benefit from an instructional program at this time?	**YES**		**NO**		**INITIALS**	
5. Can the student receive instructional services without endangering the health and/ or safety of the instructor?	**YES**		**NO**		**INITIALS**	
6. Is the patient receiving regular counseling? If not, the student is ineligible for homebound services.	Frequency of counseling __________ Expected duration of counseling __________ No Counseling __________(student is ineligible)					

7. What specific limitations of the patient are preventing school attendance?	

Section 3 – Hospital/Homebound Instructional Program

NOTE: Students entering the Hospital/Homebound Instructional Program will be placed in the most restrictive educational and social environment in which the student will not have physical contact with their peers during the school day.

8. Do you recommend the student be placed in this most restrictive environment?	**YES**		**NO**		**INITIALS**	
9. What is the requested duration of homebound services? (8 weeks is the maximum time without further referral from a psychiatrist or licensed psychologist. It is required that the patient re-visit the psychiatrist or licensed psychologist and hava a new referral completed if the student cannot return to school after the initial requested time.	**3 weeks**		**4 weeks**		**6 weeks**	**8 weeks**

10. List prescribed medication (s) and any side effects relevant to academics	
11. Describe the plan of treatment and how it will affect academic instruction:	

12. List the mental/emotional needs / accommodations necessary for the student to return to school:						
13. In order to monitor the patient's condition, follow-up visits will be scheduled with your office:	**WEEKLY**		**MONTHLY**		**OTHER (SPECIFY)**	
14. When do you recommend the student begin home instruction?						
15. When is the anticipated return to school date?						

____
Psychiatrist or Licensed Psychologist's Signature

____
Medical License Number

____
Print Psychiatrist or Licensed Psychologist's Name

____
Date completed

(______)______________________________
Office Telephone Number

(______)______________________________
Fax Number

Please return form to:

Grant Parish School Board
ATTN: Denise Young/Homebound Services
P. O. Box 208
Colfax, LA 71417