HOME/HOSPITAL INSTRUCTION SERVICES

In accordance with the Illinois School Code (105 ILCS 5/14-13.01(a)) and Illinois Administrative Code (Ill. Admin. Code 226.300), a student may qualify for home or hospital instruction if it is anticipated that, due to a medical condition (physical or mental), the student will be unable to attend school, and instead must be instructed at home or in the hospital, for a period of two (2) or more consecutive weeks or on an ongoing intermittent basis. Students are not required to have an IEP or 504 Plan to receive home/hospital instruction, however, either may be completed or revised depending on the student's needs.

The Home/Hospital Instruction Request Form ("Form") must be fully completed, including clear responses from the medical provider, prior to the commencement of services. The District will require a new request for home/hospital instruction form to be filled out every 12 weeks.

STUDENT INFORMATION

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ School Name: _____

Date of Birth:_____ Student ID:_____ Grade:_____

Parent/Guardian Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

Email Address:_____ Work Phone:_____

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; 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 Date

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 below 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 Date

_____ _____

Student Signature* Date

**Student signature required for mental health records if Student is 12 years of age or older*

MEDICAL PROVIDER INFORMATION

This section must be completed by the Medical Provider.

Medical Provider Name: _____ NPI: _____

Medical Provider: ❑ Physician ❑ Physician's Assistant ❑ Advanced Practice Registered Nurse

Phone:_____ Fax:_____ Email:_____

Medical Provider's Signature:_____ Date:_____

STUDENT ELIGIBILITY

This section must be completed by the Medical Provider.

❑ **Home:** Student's medical diagnosis impedes their ability to leave the home for instruction/services.

*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.

Start Date:_____ End Date:_____

❑ **Intermittent:** Student's medical diagnosis creates the need for the student to receive instruction/services in the home setting on an intermittent basis.

*The student's medical condition is of such a nature or severity that it is anticipated that the child will be absent from school due to the medical condition for periods of at least two (2) days at a time multiple times during the school year totaling at least ten (10) days or more of absences. If it is anticipated that the student will be unable to attend school intermittently for more than 12 weeks, the District will require a new request for home instruction form to be filled out every 12 weeks.

Start Date:_____ End Date:_____

Diagnosis impeding the Student's ability to attend school: _____

Date of Most Recent Medical Examination: _____ Date of Diagnosis: _____

Describe the nature/extent of the diagnosis. _____

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

_____

Could the Student attend school if accommodations were made? ❑ Yes ❑ No

If yes, please describe potential reasonable accommodations. If not, please explain.

_____

_____

Does the above identified medical diagnosis place the student at extreme risk of severe illness if exposed to COVID-19?

❑ Yes ❑ No If yes, please explain._____

Has the student been fully vaccinated against COVID-19? ❑ Yes ❑ No

SCHOOL INFORMATION

This section is to be completed by the school team authorizing the provision of home/hospital instruction.

I, _____ (name of school staff completing the Form) reviewed all sections of this Home/Hospital Instruction Request Form and determined the information to be complete. I therefore authorize the provision of home/hospital instruction to begin on _____ and end on _____.

_____ _____

Signature of School Staff Authorized to Approve Home/Hospital Instruction Date