Hunterdon Central Regional High School
"Performance Excellence for Everyone"
84 Route 31
Flemington, New Jersey 08822
(908) 782-5727

APPLICATION FOR HOME INSTRUCTION

PART 1-
To Be Completed by Parent/Guardian

Name of Student:_____
(LAST NAME) (FIRST NAME)

DOB:_____ **Gender:**_____ **Grade:**_____

Name of Parent/Guardian: _____

Address:_____

City:_____**Zip Code:**_____**Phone #:**_____

Last date of attendance at school:_____

Please read and check the following statements/policies for Home Instruction. Home Instruction will not be approved unless your student's physician or psychologist order is enclosed and is reviewed and approved by our school physician. Please note that home instruction will require an update from your student's physician or psychologist, every 30 days.

- ☐ **I have enclosed a completed copy of Initial Physician or Psychologist Order (pages 2 and 3 of this packet.)**
- ☐ **I authorize the school nurse, school physician, and school psychologist to contact the treating physician(s) or psychologist(s) for the release of medical information that would impact a student's academic program.**
- ☐ **I understand that for home instruction to take place in a student's home, a responsible adult(age 21+) must be present for the duration of each scheduled instructional session.**
- ☐ **I understand that if home instruction extends beyond 45 school days, all courses will be graded as pass/fail. This is because we know the challenges that can occur returning to school after missing 45 days of instruction in the classroom.**
- ☐ **I understand that the HCRHS Attendance Policy will go into effect if the home instruction is not renewed.**
- ☐ **I understand that if home instruction extends beyond 60 calendar days, student's are referred to the Child Study Team. This does not mean that students will be classified under special education, rather it is to ensure we are not missing anything.**

_____

Parent/Guardian Signature **Date**

APPLICATION FOR HOME INSTRUCTION

PART 2-
To Be Completed by Attending Physician

Student's Name:_____ **DOB:**_____ **Grade:**_____

Attending Physicians or Psychologist's name:_____

Address:_____

Date of examination:_____

Diagnosis:_____

Recommendations for special treatment, care or training:_____

_____

_____

Anticipated duration of absence from school:_____

Is the injury/illness due to school related activity? Yes No

If yes, please explain:_____

Detailed Treatment Plan:_____

_____

_____

Oral medication name and dosage:_____

Can the medication be administered at school? Yes No

Surgery:_____

Was the student hospitalized for this condition? Yes No

Does the student attend physical therapy? Yes No

Does the student attend/require psychological therapy? Yes No

Does the student attend/require cognitive therapy? Yes No

Please explain any questions to which you answered "yes"

_____

(cont'd)

_____

☐ **This student may return to school full time on:**_____
(date)

☐ **This student may return to school part time on:**_____
(date)

☐ **This student may not return to school. Please explain as to why this student may not return to school:**

_____

_____

Is this student's attendance at school a potential health hazard to themselves or others at school?

Yes No

If yes, please explain and list accommodations or restrictions and an end date:_____

_____

_____

Statement of Physician: **Please Circle**

1. **This student in their present condition, is physically and mentally capable of profiting from home instruction.** **Yes No**
2. **A home instructor can work with this student without subjecting themselves to an unreasonable risk of contagion.** **Yes No**

Attending Physician's or Psychologist's Signature

_____**Date:**_____

Attending Physician's or Psychologist's Stamp:

_____**Date:**_____

APPLICATION FOR HOME INSTRUCTION

PART 3-
To Be Completed by School Physician

I have reviewed the report of the attending physician(s) or psychologist(s) and:

_____Concur with the determination that the student is eligible for home instruction.

_____Do not concur with the determination that the student is eligible for home instruction.
(Explain)_____

_____

_____

School Physician Signature:_____Date:_____

School Nurse sends completed form to Home Instruction Coordinator

Home Instruction Coordinator sends copy to:
School Counselor
CST Case Manager (if applicable)