

**TOMS RIVER REGIONAL SCHOOLS
HOMEBOUND INSTRUCTION REQUEST FORM**

This form **MUST** be completed in its entirety by a medical professional. Homebound instruction is a **TEMPORARY PLACEMENT**, not a long-term educational option, and there is no guarantee homebound instruction will be approved. All emotional, behavioral, and psychological conditions must be documented by a psychiatrist/LCSW. Pediatrician requests are not accepted. Length of homebound may not exceed 60 calendar days.

New Request Extension Request

Student's Name: _____ Student's ID #: _____

Student's School: _____ Student's Grade: _____

Physician Name: _____ Physician Phone: _____

Physician Address: _____ Physician Fax: _____

Physician Address: _____ Physician Email: _____

Diagnosis: _____

Treatment Plan: _____

Medication: _____

Is child contagious? If Yes, explain: _____

If extension, medical reason why: _____

Length of Absence: _____

Return to School Plan: _____

Is counseling required: _____ If so, how often: _____

Can modifications be made so the student can attend the regular school program (i.e.: Early/Late start time; modified schedule;...)

Date of Next Office Visit: _____ Physician Signature or Stamp: _____

Parent/Guardian Release: I authorize the release and exchange of all medical information and health records between my child's physician/health care provider and the school district physician.

Parent/Guardian Signature: _____ Date: _____

SCHOOL USE ONLY

Medical Homebound:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Administrative Homebound:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes: <input type="checkbox"/> Suspension (attach a copy of the discipline form)
			<input type="checkbox"/> IEP Pending
Student has a 504:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(Attach a copy of page 1 of the 504)
Student has an IEP:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(Attach a copy of page 1 of the IEP)
Manifestation Determination Req.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(CST meeting for IEP student on homebound for suspension)

Case Manager Signature: _____ Date: _____

Instruction Start/End Date: _____ # Hours Week: _____

School Administrator Signature: _____

District Physician Decision: Approved Denied w/Reason: _____

District Physician Signature: _____ Date: _____

District Physician Notes: _____

District Director Signature: _____ Date: _____