

CITY SCHOOL DISTRICT
Syracuse, New York
Health Services Department
725 Harrison Street
Syracuse, NY 13210
Phone: 435-4145
Fax: 435-4859

APPLICATION FOR HOMEBOUND INSTRUCTION OR OPERATION SCHOOL

You have requested your child participate in the Syracuse City School District Homebound Instructional Program. The program is designed for students with severe temporary medical or psychological problems or psychological conditions to provide some instruction while the student is under treatment. The instruction is provided by certified teachers who come to the student's house or other meeting place. High School, Middle School and Special Education students receive Homebound Instruction for 2 hours/day, 10 hours/week. Elementary students receive Homebound Instruction for 5 hours/week. It is not a substitute for the classroom. Nor are students able to fully acquire the knowledge in Homebound Instruction in which they would otherwise acquire at school.

The following is required to apply for Homebound/Operation School Instruction:

1. Homebound/Operation School Application
2. Temporary medical evaluation and completion of application by a physician.
3. Psychological diagnoses must be completed by a medical physician.
4. Maternity Leave form to be completed by attending physician.
5. Monthly reviews and updates as necessary.
6. All Homebound/Operation School Instruction will expire after **90** days. A new application will be required with all medical updates including committee review at that time.
7. An annual well child exam or physical exam must be attached to this form.
8. Homebound Applications must be submitted through the School Nurse.

APPLICATION FOR HOMEBOUND OR OPERATION SCHOOL

HOMEBOUND

Homebound will be reserved for the following conditions **ONLY**:

1. major surgical operations
2. major orthopedic conditions
3. medical catastrophes
4. psychiatric conditions form must be completed by a physician

OPERATION SCHOOL

All medical records must be reviewed prior to approval. Reserved **ONLY** for:

1. students with sickle cell
2. students with cancer
3. severe respiratory disability (must document hospitalization and lung capacity evaluation by your physician)

All cases will be reviewed every 90 days for on-going treatment. Please attach as much medical information as possible to support your application in case your child meets other criteria for other programs.

All spaces must be completed in full and accurately or the application will be rejected.

Student's Name: _____ Birthdate: _____

Date of Application: _____ School: _____ Grade: _____

Mailing Address: _____

Parent/Guardian Name: _____

Current Phone Numbers: Home: _____ Work: _____ Cell: _____ Pager: _____

Emergency Contact and Phone Number: _____

Medical Physician's Name, Phone Number and Address: _____

Reason for request of Homebound/Operation School from a parent or guardian:

Are you requesting Homebound Instruction *or* Operation School? _____

Why do you feel Homebound/Operation School will help your child?

How long do you think your child will be receiving homebound if approved?

Do you understand Homebound/Operation School Instruction *is not* a substitute for the classroom?

yes _____ no _____ initial _____

Do you understand that Homebound/Operation Instruction will expire every 90 days?

yes _____ no _____ initial _____

Do you understand that you need to provide a medical or psychological update every 90 days (**you will not be reminded**)? Failure to do so will result in termination and reapplication.

yes _____ no _____ initial _____

Did you obtain and attach a copy of your child's annual physical exam? yes _____

no _____ initial _____

Student's Name _____

Birthdate _____

For Psychological reasons:

1. Describe previous attempts to bring your child into a regular classroom?

2. Does your child meet special needs criteria? yes ____ no ____

If no, have you attempted to have your child tested? yes ____ no ____

3. Have you discussed your child with your principal to determine if your child can be reasonably accommodated? yes ____ no ____

Explain: _____

4. What medications is your child on for his/her condition? _____

5. How long have they been on these medications? _____

6. Have you applied for Operation School? yes ____ no ____

Explain: _____

Student's Name: _____ School ID #: _____

DOB: _____ School: _____

MATERNITY LEAVE

To be completed by attending physician.

Estimated Date of Delivery: _____

Date of Last Period: _____

Date Homebound is to Begin: _____

(District policy states that Homebound Instruction should not begin until 2 weeks prior to delivery date unless there are serious complications.)

Anticipated End Date: _____

Date Homebound is to Begin Due to Complications: _____

Can there be made any reasonable accommodations to keep your patient in the classroom?

Describe Complications: _____

School Name _____

Birthdate _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

(NP, PA, PHD, AND MSW will need to be cosigned by a physician)

Your patient has applied for Homebound Instruction. This is not a substitute for the classroom and will only provide 2 hours/day, 10 hours/week of tutoring for High School, Middle School and Special Education students. For Elementary students it will provide 5 hours/week only. Please be certain your patient requires Homebound Instruction before you complete this form: An annual physical exam must be attached to this application.

1. Medical Diagnosis: _____

2. Medications being used for treatment: _____

3. Current status/disposition of patient: _____

4. Anticipated end date: _____

(Parents are required to provide medical update every 90 days.)

5. Last office visit: _____

6. How frequently do you see the patient? _____

7. Why is your patient unable to be instructed in a regular educational setting? _____

8. Can there be made any reasonable accommodations to keep your patient in the classroom? _____

Thank you for your time. Please provide medical updates as requested. Attached is a medical release of information.

Physician Signature

Please PRINT Physician Name

Date

Phone Number

Fax Number

Address

TO BE COMPLETED BY MEDICAL DIRECTOR OR NURSING SUPERVISOR

DATE: _____ APPROVED: _____ DISAPPROVED: _____ ANNUAL EXAM RECEIVED _____

SIGNATURE OF MEDICAL DIRECTOR OR NURSING SUPERVISOR

FOR HOMEBOUND INSTRUCTION DEPARTMENT USE

Instruction will begin/began _____

Homebound/Operation School Teacher _____

Hours per Week of Service _____ Date Assignment Closed _____

Disposition of Case _____

COMMITTEE REVIEW

Initial _____ Patient Reviewed _____ Comments _____

Updates _____ Comments _____



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DO NOT WRITE BELOW. TO BE SENT TO PARENT.

Your child has been approved for Homebound Services as of _____ to _____.

*(*Homebound extensions will be considered IF an update by the physician is received in Dr. Kulak's office by the date listed above.)*

The homebound teacher's name is _____ and can be reached at _____.

If you have not heard from this homebound teacher, please make contact at the number listed above.