



*Please complete all sections prior to submission to Home and Hospital Program for consideration. Eligibility is determined by Home and Hospital team after review of completed application.*

**Request for Consideration of Home and Hospital Instruction**

**PART 1- To be completed by parent or guardian and submitted with a completed "Authorization for Use or Disclosure of Health Information to and from Schools" for consideration of services.**

Date: \_\_\_\_\_ Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
School of attendance: \_\_\_\_\_ Neighborhood School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent Name: \_\_\_\_\_ Parent Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
Does the student receive special education services? (briefly describe) \_\_\_\_\_

**PART 2-To be completed by appropriate school personnel.**

Describe alternatives/options/accommodations considered and attempted at your site:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Member Completing Form: \_\_\_\_\_ Title: \_\_\_\_\_

**Final authorization of Home Instruction is made by Home and Hospital personnel.**

**PART 3- To be completed by the attending physician and returned to the parent.**

*Home instruction is a program to provide individual instructional assistance to students who are unable to attend school due to a temporary illness or injury.*

**The following section must be completed for home instruction consideration.**

ICD-9 Diagnosis: \_\_\_\_\_

*Student is **NOT** contagious or infectious. The student must require Home and Hospital Instruction for a minimum period of 20 school days from the date this form is received by the Home and Hospital Program. Hours of educational services provided are based on the student's ability to tolerate instruction, up to five hours per week.*

Physician's recommendation is for:  Home instruction **or**  
 Continued instruction at school site with modifications:  
 Modified schedule  Individualized assistance  Mobility supports

Student may return to school on: \_\_\_\_\_ (By law this date cannot exceed one year of request date)

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ State License Number: \_\_\_\_\_ Date: \_\_\_\_\_