

To Parent/Guardian: Homebound Instruction is a temporary service for students who will be out of school because they are too medically ill to attend school or have sustained a serious injury that prevents school attendance. Students who will be absent more than 2 weeks should have this form completed. Homebound Instruction is not intended to be a long-term educational placement and will not be approved as a substitute for regular school attendance.

ENTER SCHOOL YEAR _____

RETURN COMPLETED REQUEST BY MAIL OR FAX.

Health Services – Room 430 341 S. Bellefield Avenue (15213)	Phone: 412-529-3942 Fax: 412-622-3927
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PARENT/GUARDIAN AND PHYSICIAN MUST SIGN THIS REQUEST. ANY MISSING SIGNATURES WILL DELAY PROCESSING.

PARENT'S SECTION: Please Print Clearly

Gender: M F Non-Binary

Student's Name _____ D.O.B. _____

Preferred Name: _____

School _____ Date Last Attended _____ Grade _____

Parent/Guardian _____

Address _____ Zip Code _____

Home Phone _____ Alternate Phone _____

Does student have an IEP? YES NO If yes, _____

Does student have a 504 Plan? YES NO If yes, why? _____

Provide name of school staff who you notified of your child's absence. _____

Have you requested school assignments? NO YES If no, why? _____

Have assignments been provided? NO YES If no, why? _____

Why is student unable to attend school? _____

If student is pregnant, please provided due date. _____

Has student ever stayed in the hospital for this reason? NO YES If yes, when and where? _____

Has student ever received Homebound Instruction before? NO YES If yes, when and why? _____

Enter Name of Physician _____ Phone _____

Physician's Address _____ Zip Code _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information only pertaining to this request to the Office of Health Services, Pittsburgh Public Schools.

Signature of Parent/Guardian Relationship

Print Name Date

REQUEST FOR HOMEBOUND INSTRUCTION

PHYSICIAN'S SECTION: PLEASE PRINT CLEARLY AND ANSWER ALL QUESTIONS

To Physician: Homebound Instruction is a **temporary** service for students who will be out of school for more than 2-weeks because they are too medically ill to attend school or have sustained a serious injury that prevents school attendance. Homebound Instruction **is not intended to be a long-term alternative to regular school attendance.** Homebound Instruction Requests for **mental health reasons must include a treatment plan. The treatment plan must identify a specific re-entry plan for returning to school.**

I hereby certify that _____ D.O.B. _____
Patient's Name

Is my patient. Date of Evaluation _____ Provide diagnosis and reason for homebound instruction:

List Medications/Treatment Recommended _____

IF PREGNANT, PROVIDE DUE DATE: _____

Date student was advised to stop attending school. _____ If student is having surgery, date when student is able to receive homebound instruction. _____ Can student attend school on a modified school schedule? NO or YES
 If not, why? _____
 If yes, please define. (1/2 days, modified week, etc.) _____

DATE STUDENT CAN RETURN TO SCHOOL <small>(RETURN DATE MUST BE PROVIDED; AN EXTENSION CAN BE REQUESTED)</small>
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NOTE: REQUEST MUST BE CO-SIGNED BY THE COLLABORATING/SUPERVISING M.D. OR D.O. FOR MEDICAL PROFESSIONALS WITH THESE LICENSURES – MT, CNM, PA-C, DNP, CRNP OR THE REQUEST WILL BE RETURNED. REQUEST COMPLETED BY A CMA, MA OR RN WILL NOT BE ACCEPTED.

Physician's Name & Licensure (PLEASE PRINT CLEARLY)	Physician's Signature (Signature Stamp Not Acceptable)	Date
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Phone	Address	Zip Code
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Physician's Name & Licensure (please print clearly)	Physician's Signature (Signature Stamp Not Acceptable)
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Section to be completed by: LSW, Psychologist, Counselor if reason is of a mental health nature, (attach additional paperwork if necessary)
CURRENT LEVEL OF TREATMENT: _____ _____ _____
Has hospitalization or a partial hospitalization program been recommended? YES <input type="checkbox"/> NO <input type="checkbox"/> If not, why since student is unable to attend school. _____
Name and Phone Number _____

HEALTH SERVICES - PITTSBURGH PUBLIC SCHOOLS USE ONLY

Not Approved <input type="checkbox"/>	Approved <input type="checkbox"/>	End Date:	Date Request Received
Comments		Medical Consultant	Date
		Health Services	Date