



Forest City Regional School District

100 Susquehanna Street, Forest City, PA 18421-1399

Phone: 570 785-2403 ▪ Fax: 570 785-9557

www.fcrsd.org

Application for Homebound Instruction

The Forest City Regional School District believes that students must attend school if they are physically and psychologically able to do so in order to maximize their educational, social, developmental, and extra-curricular opportunities. Homebound instruction is designed to fulfill the educational requirements of students who are unable to attend school in a regular classroom setting because of a temporary illness or disability.

The Pennsylvania Department of Education requires that homebound instruction is not to exceed three (3) months. If your child's condition should require homebound instruction for more than three (3) months you will have to submit a new referral from the licensed medical practitioner before the initial application expires.

In order for a student to receive homebound instruction, he/she must be medically/psychologically unable to attend school for a minimum of ten days. The information that you provide will be reviewed by the Supervising Administrator to determine the extent of the homebound services that will be approved.

The attached parent and physician applications for homebound instruction must be completed and returned to the building principal.

Please contact your building principal if you have any questions or concerns related to homebound instruction.



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Parent Application for Homebound Instruction

Student Name

Grade

Date of Birth

IEP: Yes No 504 Agreement: Yes No

Street Address

City

Phone Number

Parent/Guardian Name

Parent E-mail

Name of Referring Physician

Physician Street Address and Phone Number

Approximate dates for homebound instruction: _____

Reason for referral: _____

Parent Signature

Date

Do you give the Forest City Regional School District permission to speak with the referring physician if the district has any questions? Note that in the absence of adequate information from a referring physician or psychologist the FCRSD reserves the right to deny the homebound request.

☐ I give permission for the FCRSD to communicate with the referring physician or psychologist.

Parent Signature

Date

☐ I do not give permission for the FCRSD to communicate with the referring physician or psychologist.

Parent Signature

Date

The Forest City Regional School District is an equal opportunity institution and will not discriminate on the basis of race, color, national origin, sex, age, and/or handicap in its activities, programs or employment practices as required by the Title VII, Title XI, Section 504, and the Age Discrimination Act. If you feel your rights were violated, please contact the Business Manager at 570 785-2406.



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Application for Homebound Instruction Physician/Psychologist Statement

Authorization for release of health information:

I request that my child be provided homebound instruction services. I authorize appropriate school personnel to contact my child's physician/psychologist listed on this form for information related to this request at any time during the period that services are required. I understand the District's right to gather sufficient information to support this request.

The requested information will be maintained in accordance with the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPPA).

Parent/Guardian Signature

Date

In order for a student to receive homebound instruction, he/she must be medically unable to attend school for a minimum of ten days. The information provided will be reviewed by the Supervising Administrator to determine the extent of homebound services that will be approved.

Student Name

Grade

Date of Birth

Parent/Guardian Name

Street Address

City

Phone Number

Dates student will be confined in a hospital: _____

Dates student will be confined at home: _____

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Reason for Referral (include diagnosis and why regular school setting is not appropriate):

Are there any reasonable accommodations that would make it possible for your patient to attend school? ☐ Yes ☐ No

Please describe those accommodations or if not possible, please explain why there are no reasonable accommodations.

What is the transition plan for the student to return to school?

Will the student be taking any medications that would have an effect on his/her ability to comprehend instruction, complete independent assignments, or work with the homebound instructor for a minimum of one hour per session? If so, please explain.

Physician/Psychologist Certification:

I understand that homebound instruction is intended to provide short-term instruction (five hours per week for a maximum of three months) and cannot replace or duplicate school-based instruction. I certify that this student is under my care and that my recommendation for homebound instruction is based on the medical or psychological needs of the patient.

Name of Physician/Psychologist

Area of Specialty

Physician/Psychologist Signature

Date

Physician/Psychologist Address

Phone Number

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