# *BELLE VERNON AREA SCHOOL DISTRICT*

**270 Crest Avenue, Belle Vernon, Pennsylvania 15012**
**Phone 724/808-2500 ext. 1500**
**Fax 724-929-5598**


## REQUEST FOR HOMEBOUND INSTRUCTION

**PARENT REQUEST:** _____New Request _____ Homebound Renewal

I hereby apply for Homebound Instruction for my son/daughter _____, who is in Grade _____ in the _____ School, and who is now unable to attend school because of physical and/or mental disability. The doctor's recommendations for schooling follow below.

| | |
|---|---|
| **Legal Parent/Guardian Name** | **Mobile Phone:**<br>**Home Phone:** |
| **Legal Parent/Guardian Address** | **Date:** |

**PARENT RELEASE OF INFORMATION:**

I request that my child be provided Homebound Instruction. I authorize the appropriate school personnel to contact my child's physician/psychologist listed below for information related to this request at any time during the period where such services are needed. I understand the District's right to gather sufficient information to support this request. [This information will be maintained in accordance with the Family Educational Rights and Privacy Act or FERPA (35 CFR Part 99).]

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

**PHYSICIAN'S STATEMENT REGARING HOMEBOUND ON REVERSE.**

***Please note: A re-evaluation by a physician is required every 90 days.***

**PHYSICIAN/PSYCHOLOGIST STATEMENT REGARDING HOMEBOUND:**

Child's name: _____ Grade: _____

I find the above named child to have the following disability prohibiting school attendance and warranting Homebound Instruction:

| | |
|---|---|
| **Diagnosis** | |
| **Description of Disability** | |
| **Prognosis** | |

Is the child physically unable to attend his/her regular public school? ____Y ____N

Is the child physically able to carry on Homebound Instruction? ____Y ____N

***Please note: A re-evaluation by a physician is required every 90 days.***

| | |
|---|---|
| **Approximate Length of Homebound:**<br>**From:**<br>**To:** | **Recommendations:** ___ **Sitting** ___ **Lying** ___ **Writing** ___ **Other (please specify)** |

_____ _____

NAME OF PHYSICIAN/PSYCHOLOGIST SIGNATURE

_____

DATE

_____ _____

PHONE

_____

ADDRESS

| | |
|---|---|
| **HB Program Manager & Superintendent Approval** | **X**_____ **X**_____ |