MEDICAL REQUEST FOR HOME INSTRUCTION TO BE COMPLETED BY TREATING PHYSICIAN

_____ is under my care for _____
(Student's name) (Diagnosis)

What limitations does this diagnosis cause? (e.g. severely limits ambulation)

_____

_____

How does this limitation affect the student's ability to attend school? (e.g., increases risk for fractures.)

_____

_____

Expected duration of the limitation: _____

Additional Comments: (please attach additional sheets as needed)

_____

_____

I request home instruction to be provided for _____ weeks (minimum 4 weeks).*

I can be reached at: Tel. _____ and/or Beeper _____

on Mon. _____ (hrs); Tues. _____ (hrs); Wed. _____ (hrs); Thur. _____ (hrs); Fri. _____

Provider's Original Signature _____ License# _____

Print Name/ Degree_____ Date_____

PARENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

Please complete the attached Authorization for Release of Health Information Pursuant to HIPPA. This form is necessary in the event additional information is required from your physician to approve the request for Home Instruction.

FOR SCHOOL USE ONLY

Student's Name _____ DOB _____ ID# _____

Address _____

*****Hours of instruction for grades K-6 are 5 hours per week and 10 hours per week for grades 7-12.

Home Instruction School Tel: 718-794-7200
3450 E. Tremont Ave. Fax: 718-794-7232
Bronx, N.Y. 10465

(Please complete the attached Authorization for Release of Health Information Pursuant to HIPAA, the Consent Form being utilized by the NYC Department of Education for the release of medical information for Home Instruction Services.)