WASHINGTON TOWNSHIP PUBLIC SCHOOLS
Director of District School Counseling
519 Hurffville Cross Keys Road
Sewell, NJ 08080

School **Contact** **Phone** **Fax**

HOME INSTRUCTION APPLICATION & SERVICES PLAN

I. STUDENT INFORMATION

a. Check one: ☐ Student with an IEP ☐ Non-disabled Student | b. Case Manager: | Ext.

c. Date of Application: ☐ Initial ☐ Extension (circle one) #1 #2 #3

d. Check Type of Application: ☐ Medical ☐ Re-evaluation ☐ Suspension/Expulsion ☐ Other (explain): _____

e. Name of Student:	f. DOB:	g. School:	h. Grade:
i. Parent/Guardian:			
j. Address:	City:	State: NJ	Zip:
k. Home Phone: ( )	Cell: ( )	Work: ( )	

II. CONSENT FOR RELEASE OF INFORMATION

I authorize the release of medical, educational, or mental health information to school officials.

_____ _____

Signature of Parent/Legal Guardian/Surrogate Parent/Student (age 18+) Date

III. MEDICAL INFORMATION (To be completed by physician)

Completion of this form with physician's signature certifies the need for home instruction, due to the conditions listed below. Please complete (as specifically as possible) the diagnosis, symptoms, and prognosis including limits in place for this student. *Note: Washington Township Public School **will not provide** home instruction until the physician's recommendation for home instruction has been verified by the school doctor. The student named above is being treated by me and will need home instruction.*

a. Does condition prevent student from maintaining school schedule? ☐ Yes ☐ No

b. Medical or psychological diagnosis:
If pregnant, please indicate due date: _____

c. Is this a chronic health condition that may require intermittent services? ☐ Yes ☐ No

d. Symptoms:

e. Prognosis:

f. Recommendations and explanations of diagnosis *(Note: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into the regular school environment as soon as possible.)*:

g. Number of weeks student will require HI services: _____ weeks Date of hospitalization: _____

h. Anticipated date student will return to school (tentative): **mm/dd/yy**

Note: Written doctor's release required for student to return to school.

Physician must sign and date below.	Physician's stamp must be affixed in this area.
_____ Signature Date Fax #: _____	

Indicate area of Licensed Speciality: ☐ M.D. ☐ D.O. ☐ Psychiatrist ☐ Neurologist

Parent permission to implement services plan: _____ Date _____

STUDENT NAME: _____ DOB: _____

IV. SCHOOL NURSE USE ONLY

a. _____	b. _____	c. _____
Date recommendation received	Date verification received	Nurse's signature

V. WTPS PHYSICIAN CONFIRMATION ONLY

Note: This form must be reviewed and returned to the school nurse (via fax or school courier) within three (3) days.

☐ I have reviewed this application and I approve the provision of homebound instruction services.

☐ I have reviewed this application and I **do not** approve the provision of home instruction services.

Rationale for denial of services: _____

_____

_____ _____

Signature of Dr. Theodore Koerner Date

VI. COUNSELOR/TEACHER USE ONLY

Teacher: Please indicate on the chart below, your interest (or non-interest*) and return this form to Counseling **before** the end of the school day.

*If NOT INTERESTED, please submit an outline of all assignments to be completed; include instructional materials (textbooks, workbooks, worksheets, etc.) for the assigned tutor to utilize during the home instruction time period. All materials must be submitted to the **COUNSELING OFFICE**, as soon as possible. Your cooperation will expedite the home instruction process and is greatly appreciated.

	Teacher Name	Instructional Area	Time Period Requested	Interested	NOT Interested	Instructor/ Service Provider
1				☐	☐	
2				☐	☐	
3				☐	☐	
4				☐	☐	
5				☐	☐	
6				☐	☐	
7				☐	☐	
8				☐	☐	
9				☐	☐	

VII. ADMINISTRATIVE USE ONLY

Home Instruction Service Plan Approved:

_____ _____

Principal *Date* *Director of District School Counseling* *Date*

VIII. RETURN TO SCHOOL

The above named student has been determine medically able to return to school and may return on _____.
(Doctor's release must be given to school nurse). Return Date

_____

School Nurse's Signature *Date*

The school nurse must notify the student's School Counselor of the return to school date. In addition, a copy of this form must be sent to the Director of District School Counseling.