HOMEBOUND APPLICATION FORM

This form should be initiated by the School Nurse Consultant for any parent requesting that their student be placed on homebound status due to illness or surgery.

This form should be completed (except for the physician statement section) by the Case Manager of any student currently on an IEP that has been expelled.

Please Note: Parent/Guardian: Please sign form indicating your approval of homebound educational support for your child. Student's physician must complete and sign Section II. **Form should be returned to student's school nurse consultant.**

Section 1: STUDENT INFORMATION

Student Name:_____ Student ID# _____

School_____ Birthdate:_____ Grade _____

Address: _____

Home Phone #: _____ Parent Work Phone #: _____

Cell Phone #: _____ Parent Email address: _____

I hereby give my consent for appropriate school representatives to contact my child's physician regarding his/her condition.

_____ _____

Signature of Parent/Guardian Please print name

Please Note: Homebound education is a service for students who, for severe physical or severe emotional reasons, are unable to participate in any activities outside the home beyond appointments, medical tests and therapy. The student must be unable to participate in an on-site traditional educational program for two weeks or more before being considered homebound eligible.

Section 2: PHYSICIAN STATEMENT

Diagnosis: _____

Specific reason for homebound need:_____

_____

Length of time student will be unable to attend school (Please be specific): _____

_____

Name and address of physician: _____

_____

_____ Phone #: _____

Signature: _____ Date: _____

For School Use Only

Initial Contact Person/Classroom Teacher: _____ Date of Contact: _____

Signature of Nurse approving services: _____ Date: _____

Homebound Approved (Y/N):_____ If no, Why?: _____

504 Plan (Y/N): ___ ILP Plan (Y/N): ___ Student on current IEP (Y/N): ___ If so, Date of next IEP: _____

Case Manager's Name (Print): _____ Phone #: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM DOUGLAS COUNTY SCHOOL DISTRICT/Health Services

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Patient/Student Name: _____/ _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and /or health care providers):

(1) _____ (2)_____

To provide health information from the above-named child's medical record to and from:

_____ _____
School District to which disclosure is made Address/ City and State/ Zip Code

_____ _____
Contact person at School District Phone number of contact

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following:

- ❑ All minimum necessary health information
- ❑ Mental health related records
- ❑ Disease specific information as described:

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature if no date entered.

YOUR RIGHTS: I understand that the following rights with respect to this Authorization: I may revoke the authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this authorization.

RE-DISCLOSURE: I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the Douglas County School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of the authorization. Signing this authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: _____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Phone Number