THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

PARENT APPLICATION

Date received:_____

SECTION 1 – COMPLETED BY PARENT/LEGAL GUARDIAN

STUDENT NAME	DATE OF BIRTH		STUDENT NUMBER
ADDRESS (street name, number, apt. zip code, etc)	HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
PARENT/GUARDIAN NAME	CURRENT SCHOOL		
PARENT/GUARDIAN EMAIL	CURRENT GRADE		ANY ESE ELIGIBILITIES

Last date of school attendance _____. The current school is responsible for providing assignments and grades to the student until student is officially enrolled to receive Hospital Homebound Services. Once made eligible, the home school is responsible for providing all assigned textbooks, workbooks or any other instructional materials to the Hospital Homebound service provider.

List current courses:_____
_____
_____

Note: Not all courses may be available for HH instruction.

I hereby authorize the student's physician(s) to engage in written and/or verbal communication regarding all information concerning the diagnosis, treatment and medical implications for instruction regarding the student's current condition that is the cause of the request for the student to receive educational instruction through the Hospital Homebound Program. This release will remain in effect for one year or until the student is dismissed from the Hospital Homebound Program, whichever is earlier. A copy of this authorization is valid in lieu of the original.

Must be signed by the parent/legal guardian or student at the age of majority (18 years or older)

_____ **Date:** _____

Signature of Parent/Legal Guardian or student at age of majority

Parents, Guardians, and Students: Please read the following information regarding eligibility, policy, and procedures for the Hospital Homebound Program and sign. This application serves as the medical report and your signature grants the School Board of Broward County to determine eligibility for Hospital Homebound Services.

SECTION 2: COMPLETED BY PARENT/LEGAL GUARDIAN

ELIGIBILITY, POLICIES AND PROCEDURES

I understand that:

- Eligibility is based on receipt of a fully completed physician statement and the medical referral form is part of the information used to determine eligibility. If necessary, school instructional staff will communicate directly with the student's physician(s) to obtain additional information needed to determine eligibility for Hospital Homebound Services.
- The student must be enrolled in a public school.
- Hospital homebound Services are for students who are ***confined to the home or hospital*** due to a medical or mental condition which is acute, catastrophic or chronic.
- I will be required to sign a Parental Agreement regarding Hospital Homebound Services policies and procedures.
- If the student is found eligible for Hospital Homebound Services and circumstances change, (eg. The student is attempting to be employed, participate in extra-curricular activities, and/or a change in the student's medical condition etc.), the student may be considered for dismissal from Hospital Homebound Services and return to his/her home school.
- If the student is found eligible for Hospital Homebound Services, he or she is required to follow the same mandatory attendance requirements as other BCPS students and must follow the Code of Student Conduct.
- It is my responsibility to communicate any changes in the student's health status or concerns to the Hospital Homebound service provider.

PROGRAM DISMISSAL

Dismissal from Hospital Homebound Services may occur for the following reasons:

1. The physician recommends that the student's health has improved and the student is able to attend school.
2. If the student's circumstances change, (eg. The student is attempting to be employed, participate in extra-curricular activities, and/or a change in the student's medical condition etc.), the student may be considered for dismissal from Hospital Homebound Services and return to his/her home school.
3. The student fails to be able to attend to instruction enough to benefit from instruction or is too ill to benefit from instruction.

PARENT/LEGAL GUARDIAN PERMISSION AND RELEASE OF INFORMATION

I have read the Hospital Homebound Parent Application, policies, procedures and requirements for eligibility. I understand the possible reasons for dismissal from Hospital Homebound Services. I agree to the policies and requirements and request Hospital Homebound Services for my child. I understand that my signature below provides consent for my child to be evaluated and considered for eligibility for Hospital Homebound Services.

_____ _____

Must be signed by parent/legal guardian **Date**
Or student at age of majority (18 or older)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

PARENT/GUARDIAN CAREGIVER AGREEMENT FOR HOSPITAL HOMEBOUND SERVICES

1. My child is under the care of a licensed physician/psychiatrist in the state of Florida who certifies that my child is expected to be absent from school for at least 15 school days either consecutively or intermittently due to an acute, catastrophic, or chronic condition that causes my child to be confined to our home or the hospital.
2. My child is free from communicable diseases.
3. I will ensure that a responsible adult (age 18 or over) will be present in the home during instructional time.
4. I will provide a clean, well-lit and ventilated room with an appropriate workspace for the teacher and my child. I will provide a safe area for instructional staff to park.
5. During instructional time, there will be no smoking and pets will secured for teacher's safety.
6. I will have my child available and prepared for instruction at the specified time (normal hours of my child's school day) and will not schedule therapy or medical appointments to conflict with the instructional time.
7. Visitors will not interrupt instructional time.
8. I will notify the Hospital Homebound office if my child will be too ill to participate in instruction or I need to cancel for any reason. If we do not receive a call and no one is home during scheduled instructional time, the student will be marked as an unexcused absence.
9. I have read the Code of Student Conduct Handbook and will follow its rules and procedures.
10. I understand that service providers may schedule instructional time together in order to ensure collaboration between instructional providers and generalization of skills.
11. If my child is receiving Teleclass, I will provide an open, uninterrupted telephone line for use during instructional time.
12. I understand that Hospital Homebound services will stop on the date provided by my physician on the Physician's Referral Form. If services are needed past that date, it is my responsibility to provide a completed Hospital Homebound eligibility packet.

I FULLY UNDERSTAND AND AGREE TO FOLLOW ALL OF THE REQUIREMENTS FOR HOSPITAL HOMEBOUND SERVICES.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

_____

PRINT NAME OF PARENT/GUARDIAN

_____

NAME OF STUDENT