Lockport City School District
Application for Home Teaching for Medical Reasons

To be completed by parent/guardian:

Student Name: _____ Date of Birth: _____
Parent/Guardian Name: _____ Address: _____
Telephone Number (Home): _____ (Work): _____
Name of School Student Attends: _____ Grade:_____

I hereby grant permission for the medical staff of the Lockport City School District to obtain medical information from the ordering physician in order to evaluate the need for home teaching.

_____ _____
(Signature of Parent/Guardian) **(Date)**

Please complete and return form to:
Sheila Murphy, Director of Student Services
319 West Avenue
Lockport, NY 14094
716-478-4623
Fax – 716-478-4634
smurphy@lockportschools.net
If fax is transmitted it must be followed by the original

All applications are for one month and may be reviewed as needed every 30 days!

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To be completed by the Physician/Licensed Psychologist/Nurse Practitioner/Licensed Clinical Social Worker:

Check Type of Notice: Original: _____ Renewal: ____

This is to certify that I have made a careful examination of the above-identified student and have made the following determination:

- Physical Disability: Diagnosis: _____
- Mental Health Disability: DSM IV Diagnosis: _____
  Requires the evaluation and signature of the school or family physician and evaluation and signature of a qualified psychologist or psychiatrist.
- Pregnancy: EDC:_____ (For 6 week post partum home teaching, it is not necessary to answer questions 1-9 below).
- Other (please specify): _____

1. How does diagnosed condition inhibit the student's ability to participate in classes in the school setting? _____
2. What accommodations could be made to maintain the child in the school setting, i.e. reduced school day, use of elevator, extra time between classes, extra set of books at home, "break time" during school day? _____

3. Will attending school have a negative impact on the child? Yes: ____ No:_____

4. Are there any accommodations that the school can make to alleviate negative impact and increase positive results attending school? _____

5. Is it your recommendation that the student be confined to home or hospital? _____

6. Can the child participate in other outside activities, and if so, what? _____

7. Do you have other specific recommendations for what the child can participate in? _____

8. In order for the student to fully participate in school, what are the treatment plans and/or referrals that you are recommending for the student to improve? :_____

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9. What is the duration of the student's incapacity? _____

_____ _____

(Signature of Physician/Psychologist/NP/LCSW) **(Date)**

OFFICE STAMP: (address and phone number must be completed for application to be processed)

This application will be reviewed the district's Nurse Practitioner in collaboration with the building principal and guidance counselor for determination of educational accommodations.

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District Nurse Practitioner Use Only

__Approved __Denied _____

(School Physician/NP) (Date)

COMMENTS:

_____

4/07 SM:slm
7/08, 2/09 BS:bas
8/18 lms