Received: ____________________ Status: ________________

☐ **504** ☐ **Special Education** ☐ **IAES** *(Complete Student Information Section ONLY)*:

APPLICATION FOR HOMEBOUND INSTRUCTION

Exhibit IHBF-E-1
Revised
November 14, 2018

For students who cannot attend school due to an extended physical, mental, or emotional illness.
(Students who can attend school part time do not qualify under this program.)

A NEW APPLICATION MUST BE SUBMITTED EACH SEMESTER

SUBMIT COMPLETED APPLICATION AND MEDICAL INFORMATION RELEASE TO:
Office of Student Support and Engagement
711 East San Rafael Street
Colorado Springs, CO 80903
Phone: (719) 520-2998 Fax: (719) 520-2308 Email: homeboundtutoring@d11.org

STUDENT INFORMATION (*MUST* be completed by parent/guardian):

Name of Student: ____

School: ______________________ School Counselor/Contact Name: ______________________

Home address: ______________________ Zip: __________ Grade: __________

Birthdate: __________ Home Phone: __________ Cell/work Phone: ______________

Email address: ______________________ (Email will be primary source of contact during enrollment)

Print Parent/Guardian Name: ______________ *Parent/Guardian Signature: ______________

**This signature authorizes my physician to share the information stated below with pertinent School District 11 staff members.*

PHYSICIAN INFORMATION (*MUST* be completed by licensed healthcare provider):

To be eligible for Homebound/Hospital instruction, a student's absence must be more than 10 consecutive school days.

☐ **Pregnancy:** Approximate due date: __________ (Homebound instruction is authorized after delivery**.** In special circumstances, because of risk factors to the mother or baby, tutoring may be authorized). Please list risk factors:

____

☐ **Description of Medical Diagnosis:** (Please state why the student is unable to attend school).

____

If the student's diagnosis is communicable, include necessary procedures to be followed by the homebound instructor.

____

Calendar date to be excused from school: ______________ Calendar date to return to school: ______________

______________________ ______________________
Healthcare Provider Name Signature of Healthcare Provider*

Physician's Address: ______________ Telephone: ______________ Date Signed: __________

**Homebound instruction can only be provided with a signature from a physician or psychiatrist or other similar healthcare provider licensed in the state of Colorado. Incomplete information will be returned and will delay services. Signature does not excuse past absence from school.*