TRENTON, NEW JERSEY

APPLICATION FOR HOME INSTRUCTION

Home Instruction is not intended to replace or fulfill all requirements of the comprehensive educational program designed for grade level completion or high school graduation. Home Instruction does not excuse any mandated requirements of the NJ State Assessments, high school graduation, or Individual Educational Plan (IEP).

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SECTION I TO BE COMPLETED BY PARENT/GUARDIAN

Student: _____ **Date of Birth:**_____ **Age** _____Years Old **School**_____

Medical Condition: _____

Name of attending physician:_____

Other Reason:_____

Home Instruction request for the above student who is confined to home hospital other institution
circle one

When instruction is provided at home a quiet place free from interuptions or distractions will be provided. I understand that the parent or other designated adult 21 years or older must be present when the Home Instruction Teacher is present in the home. The school counselor or CST Case Manager is the direct contact for the parent to receive school work or course and subject grade reports.

I agree to sign the Home Instruction Work Record verifying the date and time the teacher spent providing Home Instruction.

_____ **Telephone Number/s** _____
Parent/Guardian's Name _____
_____

Email: _____

_____ Trenton, NJ _____
Address **Zip Code**

_____ _____
Parent/Guardian's Signature Date

_____ _____ _____
Name of Other Adult to be present if not above parent **Signature of Other Adult if appropriate** **Date**

SECTION II TO BE COMPLETED BY ATTENDING PHYSICIAN (Please type or print)

Student: _____ Date of Birth:_____ Age:_____

1. Medical Condition and/or Diagnosis:_____

_____

2. Anticipated length of time away from school : From _____ To:_____
If pregnancy related include estimated due date (EDC): _____

3. Comments or restrictions: _____

_____

_____ _____
Signature of Attending Physician **(STAMP NOT ACCEPTABLE)** Date

_____ _____
Print Physician Name Telephone Number

_____
Physician's Address

***Attach Physician's letter stating under his/her care**

SECTION III TO BE COMPLETED BY CHIEF SCHOOL MEDICAL INSPECTOR

Attending physician contacted Yes_____ No_____ **Home Instruction Recommended**: Yes_____ No_____

Projected termination date: _____

Comments/Recommendations: _____

_____

Chief School Medical Inspector: Jacqueline Gettys, MD **Signature**:_____ **Date**:_____

SECTION IV TO BE COMPLETED BY SCHOOL

_____**Initial Request** _____**Extension Request and date of Initial Request**_____

Name of Student_____ Grade_____ Age_____

School _____ Counselor_____ Telephone_____

Subject Course Schedule:

Subject/Course	Teacher	Subject/Course	Teacher

_____General Education Student _____Bilingua/ESL Student _____ Special Education Student _____Section 504 Student

Other Information /Remarks

_____

_____

_____

Attachments: _____Copy of the IEP for Special Education Student _____Copy of IPP for General Education Student

_____ _____ _____

School Nurse Name School Nurse Signature Date

_____ _____ _____

School Counselor Name School Counselor Signature Date

_____ _____ _____

School Principal Name School Principal Signature Date

Date Received by Nursing Supervisor:_____

Comments:_____