PLATTSBURGH CITY SCHOOL DISTRICT

Jay Lebrun
Superintendent of Schools
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4327-E

HOMEBOUND INSTRUCTION
PLATTSBURGH CITY SCHOOL DISTRICT

Request for Alternative Instruction: Due to ACUTE Medical Concerns

Note: emotional disability request must be approved by treating psychiatrist or NYS licensed clinical psychologist only. Please ensure a signed a HIPAA release is attached to allow you to speak with school physician and/or educational team members.

To Be Completed by Parent/Guardian:

Student Name:
_____

Date of Birth: _____ School: _____ Grade:
_____

Parent/Guardian:
_____

Alternative Instruction only provides 2 hours per day for secondary school, compared to approximately 7 hours per day of in-school programs. Prolonged alternative instruction is insufficient for a child to learn effectively, to socialize, or, ultimately, to graduate. Alternative instruction is a short term, stop-gap measure for ACUTE medical concerns. Alternative instruction is NOT a program, and prolonged modification requires evaluation by the Committee on Special Education (CSE). The district maintains that in almost every case, the best place for a child is in school. Accordingly, we make every effort to work with you to tailor a program that will suit the child's medical needs. All requests for alternative instruction must be accompanied by a reentry plan with a timeline and must not exceed 10 weeks without strong medical indications. We strongly discourage keeping a child out of school for school phobia for any time except for a hospitalization or intensive desensitization therapy, unless accompanied by strong medical indications. We ask that you work with the school's case manager/school counselor/school psychologist on a regular basis to aid in the successful reintegration of the child back into the school program as quickly as possible. If a child is not in active therapy, the district will not grant out-of-school instruction for emotional concerns.

Approved requests are contingent upon continuation of therapy. Please notify the school if your patient stops therapy.

I, as the parent/guardian of _____, am aware of my child's physician's and/or psychiatrist's recommendations contained in this request for alternative instruction and understand that the district will provide, in consultation with these providers, a reentry plan in order to avoid significant disruption to my child's education. I understand that any requests for extensions of initial timeframe must be accompanied by clear medical documentation.

- **I have attached a signed HIPAA release** to allow all appropriate providers to speak with the school physician, school nurse and/or educational team members regarding this particular medical concern. (This must be attached for any approval of home instruction, as we must assure validity to requests. Pre-completed HIPPA forms with appropriate school faculty, including the school physician are attached to this request, but can also be requested from the main office or nurse's office.

_____

Parent/Guardian Date

To Be Completed by Physician OR Specialist OR Treating Psychiatrist OR NYS Licensed Clinical Psychologist:

Provider name/Title (printed): _____

(Please feel free to attach business cards for ease, additional providers completing this form can be added as attachments, but all providers must sign.)

Provider practice: _____ **Phone number:** _____

Address: _____
_____
_____

Form being completed for the following
Student Name: _____
DOB: _____

Diagnosis: (*please be specific*):_____
_____
_____
_____

Prognosis: (*please be specific)*:
_____
_____
_____
_____

For Medical Concerns:

Is patient on medication for current condition? ☐ YES ☐ NO

If yes, is the medication: ☐ Stable? ☐ In Transition?

Should this medication and its indications be considered into intervention plan? ☐ YES ☐ NO

Why or why not?

_____

_ _____

Length of Alternative Instruction requested (*explain*):

_____

_____

_____

Could other modifications be put in place to allow the student to come to school such as special nursing services, word processor or any other? ☐ YES ☐ NO

What are other modifications the school could consider versus alternative instruction (if any) that would support this student's needs?

_____

_____

For emotional health concerns: Is the patient/student in active therapy? ☐ YES ☐ NO If yes:

Therapist:_____

Phone:_____

Psychiatrist:_____

Phone:_____

Primary Care Physician:_____

Phone:_____

(Only the Physicians completing or contributing to this form must sign. Physician must complete this portion of the request, but could also sign a prescription attached to this form as well, as long as form is completed and signed by the physician.) Thank you for your help in supporting our students.

Signature MD, DO, Ph.D. **Specialty or title** **Date**

NYS License #: _____ **Stamp:**

Signature MD, DO, Ph.D. **Specialty or title** **Date**

NYS License #: _____ **Stamp:**

Additional providers may put their information on an attached form.

EXTENSION REQUESTS

For second or third request, a report from school must accompany request and indicate how student has done with prior alternative instruction, including grades, tutor report, absences, and/or whether he/she is on target to graduate. Please indicate number of sessions attended/ total possible days offered. Does the administrator think extension is warranted?

Return completed form to:
Plattsburgh City School District Office
Mr. Jay Lebrun, Superintendent
Office: 518-957-6002

Adoption date: November 21, 2019

PLATTSBURGH CITY SCHOOL DISTRICT- Tutoring Log

Student Name:_____ Current Grade:_____ Building Contact: _____

Tutor's Name: _____ Location of Tutoring: _____

*** *Log for Homebound Instruction or Tutoring must be submitted weekly. The Tutor must document the time in, out, instruction and materials delivered and collected, as well as any comments or concerns. Parent/Guardian signature will be requested to verify time and instruction*****

Date	**Time In**	**Time Out**	**Instruction Delivered during Tutoring session- Academic Content** *(list subject and topics, identify assignments given and due date)*	**Work Collected to be Returned for Grading** (list subject/topic)	**Comments/Concerns** (Academic/Social/Behavioral)	**Parent/Guardian Signature**

Signature of Tutor: _____ Date: _____ Received by: _____

MISSION

Our mission is to educate each student of the Plattsburgh City School District by creating challenging, supportive, and interactive learning that advances intellectual, physical, social, and cultural development.

PLATTSBURGH CITY SCHOOL DISTRICT

PLATTSBURGH ◆NEW YORK 12901

CONSENT FOR RELEASE OF INFORMATION

Student: _____ DOB: _____

I, _____, parent/legal guardian of the above-referenced child, hereby authorize the release of written and verbal information as follows:

From: _____
To: Medical Director, Plattsburgh City School District, Plattsburgh, NY

AND

From: Medical Director, Plattsburgh City School District, Plattsburgh, NY
To: _____

Information to be released:
____Health information
____Social/emotional/behavioral observations
____Psychological Assessment results
____Academic performance information
____Treatment recommendations
____Other _____
_____

This information will be used to plan and support an appropriate academic program and provide necessary counseling and/or health services to this student.

This release expires: June 2021

I (we) understand that this release can be revoked by a written statement at any time, except for action already taken.

I understand that all information, records, and documents received under this release will become part of a school record. As part of the school record this information may be disclosed, without consent, to parties outlined under FERPA (Family Educational Rights and Privacy Act). Therefore, this information may not be protected by federal (HIPAA) confidentiality laws.

Parent/Guardian Signature _____

Date _____

The signer is entitled to a copy of this release. Copy requested: ____Yes ____No