Naperville 203
Community Unit School District

Lisa Xagas
Assistant Superintendent for Student Services

Administrative Center · 203 W. Hillside Road · Naperville, Illinois 60540-6589 · 630-420-6465 · FAX: 630-420-6566

Home/Hospital Tutoring Application

My child is unable to attend school and I am requesting: _____ Home _____Hospital (check one)

Student Name: _____ Birthdate: _____

Address: _____ Phone: _____

School: _____ Grade: _____ Date last attended:_____

I acknowledge that if I accept the instructional services, I agree to maintain the following conditions:

- Presence of an adult age 21 or older in the public location during the tutoring session.
- Presence of my child for all scheduled sessions
- Notifying the school and homebound instructor if instructional time must be cancelled
- Monitoring completion of homework as well as other assignments
- Providing an updated application and physician statement bimonthly for extended absences

Parent Signature: _____ Date: _____

*Complete and return this portion along with the Physician Statement to your student's building administration or attn.: Student Services/PSAC, Attn: Director of Student Services

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TO BE COMPLETED BY SCHOOL PERSONNEL

Student ID# _____

Student's Classes/Services:	Teacher/Service Provider:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current IEP/504 on file _____ Yes _____ No
Related Services provided _____ Yes _____ No

Date: _____ Administrator Signature: _____

*After form is completed in its entirety, please return to Student Services/PSAC, Attn: Director of Student Services.

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HOME/ HOSPITAL PHSYICIAN'S CERTIFICATION

TO BE COMPLETED BY A PHYSICIAN LICENSES TO PRACTICE MEDICINE IN ALL IS BRANCHES (M.D. OR D.O.)

Student Name: _____ Date of Birth: _____

DIAGNOSIS (Please complete the following)

Diagnosis/Injury/Surgery (Primary Diagnosis): _____

Other (Describe):_____

If the diagnosis is a disease, Is this disease communicable? _____Yes_____No

If yes, please provide instruction to school staff in the space below labeled "Special Recommendation to Teachers"

I, _____, certify that this student is unable to attend public school. I also certify that this student is medically and physically eligible to be enrolled in the following program:

Check one only _____ Home Instruction _____ Hospital Instruction

This physician must estimate that the student will require home or hospital instruction for a minimum of 10 school days this school year; the time may be longer than 10 days.

Estimate the length of time the student will need Home/Hospital instruction this school year (in weeks.)

_____

SPECIAL RECOMMENDATION TO TEACHER (e.g. diet, rest, exercise, positioning):

_____

_____

_____

Print Name of Physician

_____

Physician Contact Telephone Number

_____

Original Signature of Physician Date

For School District Use Only

Date Home/Hospital Instruction began:

_____