8450F3

HOME TUTORING (TEMPORARY INSTRUCTION) EXTENSION FORM

The Shenendehowa CSD recommends that students attend school every day to benefit from: classroom instruction; interaction with peers; use of school equipment (e.g. art and science equipment) and extracurricular activities. However, we also recognize that occasionally a student may be medically unable to attend school for a limited period of time. If it is anticipated that the student will be unable to attend for 10 or more days in a period of 3 months, we will provide a temporary alternative to the regular school experience. You may also request such temporary alternative when the anticipated duration of the absence is less than 10 days in a period of 3 months, and such instruction may be provided in the discretion of the Superintendent or the Superintendent's designee.

This form is used to provide medical verification of a student's ***continued*** temporary inability to attend regular classes at school. ***Updated*** written verification by the student's treating health care provider that the student has an illness or serious injury that ***continues*** to prevent their attendance in regular classes at school, along with a ***new return to school plan***, must accompany request for ***extension***.

Date of Extension Request:			
Name of Student	**DOB**	**School**	**Grade**
Name of Treating Health Care Provider	**Treating Health Care Provider Address**		**Treating Health Care Provider Phone #**
Reason for Extension Request and anticipated period and duration of absence:			
Does the student have an Individualized Education Plan (IEP) or a 504 Plan? **Check box: Y or N**		**Yes** ☐	**No** ☐

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Release of Information

The School Physician will review and approve this form, and may consult the treating health care provider as part of the review. If you do not consent to the School Physician's consulting the treating health care provider, alternative instruction will not be approved.

I hereby authorize the Shenendehowa Central School District's School Physician to contact the health care provider who signed the attached written medical verification to discuss the information provided.

_____ _____

Parent/ Guardian Signature **Date**

Written Medical Verification

Must be completed and signed by the person treating the student, who must be a professional licensed or otherwise authorized to provide a diagnosis under Title VIII of the New York State Education Law.

Name of Student: _____ Date: _____

Please check one of the following:

_____ The student ***continues*** to be unable to attend school at this time due to health concerns, and I do support an ***extension*** of provisions of alternative instruction (home tutoring) (***If checked please complete the remainder of the form***.)

_____The student can attend school without any type of modification or special provisions.

_____The student can attend school only with modifications or special provisions. Describe modifications needed:

_____

_____

_____

Diagnosis (**must be completed**):

_____

_____Check here if this student has a chronic physical condition that is unlikely to substantially improve within one year.

Please provide specific reasons/limitations as to why the student is unable to attend school at this time:

_____

_____

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_____

_____

How long have you been seeing the patient for the diagnosis listed? _____

Date for next follow up with patient (required) _____

New date you anticipate the student may return to school? _____

Please summarize tests and all other data collected that supports the need for the ***extension*** of tutoring at this time.

_____

_____

_____

What is the treatment plan for the patient?

_____

_____

What is the ***updated*** return to school plan? (required)

_____

_____

_____

_____ _____

Signature of Licensed Professional Print Name of Professional

Office Address:_____

Phone Number:_____

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Review by School Physician (if necessary)

I have reviewed the information provided above, and discussed it with the student's treating health care provider to the extent necessary. Based on that review, I

___ approve the extension request for tutoring services.

___ deny the request for tutoring services because _____

_____

_____

, School Physician

Instruction in Place of Regular Classroom Attendance: Review
****TO BE COMPLETED BY AUTHORIZED SCHOOL & DISTRICT ADMINISTRATOR****

Name of Student:

_____

Date ***Extension Request*** Received:_____ Approved _____ Denied _____ Incomplete _____ (See below)

If approved, date services will be provided from _____until_____ (Review Date)

List the types of service(s) that will be provided and by whom:

_____

_____

_____

If incomplete application, type of additional information requested:

_____

Administrator signature: _____ Date: _____

District Approval for ***Extension*** (required) :_____ Date: _____

Reviewed/Revised: June 9, 2020, June 7, 2022, June 26, 2023, June 4, 2024, November 5, 2024