

## PHYSICIAN'S REQUEST FOR ALTERNATIVE/HOME EDUCATION PROGRAM

Dear Physician,

Per **NJAC 6A:16-10.1**, students may be eligible for home instruction due to a temporary or chronic health condition. A physician may request this support if the anticipated absence from school is:

- **More than 10 consecutive school days**, or
- **17 cumulative school days** during the academic year.

Eligibility is reserved for cases of **long-term confinement** to home or hospital due to severe illness or injury. Confinement is defined as the student being bedridden or unable to participate in activities outside the home. Home instruction is limited to a maximum of 10 hours per week, compared to 30+ hours of in-school education

### Required Documentation

To consider an Alternate/Home Instruction Program for the student referenced, please provide the following information on the second page. This documentation will be reviewed by the school's medical and administrative team. **All fields must be completed**; incomplete submissions cannot be considered.

#### **This academic year, your patient has had:**

- Number of school absences: \_\_\_\_\_
- Number of days arrived late / left early: \_\_\_\_\_
- Number of days participated in home instruction: \_\_\_\_\_
- Last day of school attendance: \_\_\_\_\_

### Collaborative Care and Return-to-School Planning

Our shared goal is to help the student return to school as soon as medically appropriate. While home instruction can provide temporary academic support, it is not a substitute for the full educational, social, and emotional benefits of in-person learning.

We offer a range of resources to support families and facilitate a smooth transition back to school.

### Consideration of School Avoidance

If it has been more than 30 days since the student last attended school, please consider the possibility of school avoidance, which may be a symptom of pediatric anxiety disorders. We encourage you to discuss this with the family and consider escalating care if appropriate, including referrals for behavioral health support.

### Let's Work Together

Please update the student's current diagnosis and treatment plan, taking into account the attendance information provided. If you have any questions or would like to discuss the case further, we welcome the opportunity to collaborate in support of the student's well-being and educational success.

Thank you for your partnership.

Warm regards,

[Your Name]

[Your Title]

[School/District Name]

**Student:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Date of exam: \_\_\_\_\_

Diagnosis:

\_\_\_\_\_

\_\_\_\_\_

Is the student confined or unable to leave their home or a medical facility? \_\_\_Y \_\_\_N

How does their medical condition prevent the student from physically attending school?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Treatment Plan:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Can the student attend in person educations at school for part of the day? \_\_\_Y \_\_\_N

What accommodation do you believe will be necessary to facilitate the student's return to school?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Duration of the request: \_\_\_\_\_

When is the next scheduled follow-up appointment? \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Office Stamp:**

**PARENT/GUARDIAN AUTHORIZATION:** I authorize the School Nurse/ School Physician to communicate with my child's health care provider and my child's health care provider to reply as needed regarding this Referral for Home Instruction  
Parent/Guardian's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

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