Summerville Union School District
HOME/HOSPITAL
17555 Tuolumne Road
Tuolumne, CA 95379
Phone: (209) 928-4228 Fax: (209) 928-1422
Email: cjensen@summbears.net

MEDICAL REFERRAL FOR HOME INSTRUCTION

This form is valid for current school year only: _____

Last Name: _____ First Name: _____

DOB: ___/___/___ Grade: ___ Student ID: _____ Student Email: _____

Address: _____ City:_____ Zip_____

Parent/Guardian:_____ Parent/Guardian Email: _____

Last Day of Attendance: _____ Administrator Signature: _____

Does your student have a current IEP? [ ] Yes [ ] No
If yes, an Addendum needs to be completed and attached to the IEP changing placement to Home/Hospital

Section 504 Plan? [ ] Yes [ ] No Condition related to 504 Plan _____

IMPLEMENTATION OF SERVICE

HOME TEACHING – Home/Hospital will provide five (5) hours of instruction per week in a manner consistent with California laws governing home teaching. A responsible adult (18 years or older) must be present when the teacher is in the home. Students can have services in a public location; ie Library or other public establishments without adult presence.

By signing this authorization for service, the parent/guardian agrees to the following:

- If the student is eligible, educational services will be temporarily provided by Home/Hospital.
- Home/Hospital program may not be able to teach all academic subjects. This will be discussed with parent/guardian during the initial intake.
- Please be flexible with teaching times as Home/Hospital teachers have multiple students.
- Parent is responsible for contacting physician to provide paperwork if continuation of program is required.

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION AND TEMPORARILY TRANSFER EDUCATION DUTIES:

_____ _____

Parent Signature **Date**

California Licensed Physician must complete page 2 to authorize service

SUHSD USE ONLY:

Teacher Assigned: _____ Date Teacher Assigned: _____

[ ] Approved request forwarded to Registrar [ ] Forwarded to Attendance Secretary

MEDICAL REFERRAL

This form is valid for current school year only.

Student Name: _____ **D.O.B.** _____

PHYSICIAN: A request for temporary Home Instruction has been made for the above-named student. The California Education Code §44873 requires that a licensed California physician file a statement which includes a medical diagnosis to the extent that the student is unable to attend classes on any school campus. **Chronic conditions** may not qualify. **DO NOT USE THIS FORM FOR PSYCHIATRIC CONDITIONS (use Psychiatric Referral Form).**

Attending Physician's Statement

Is student physically capable of attending classes on his/her school campus now, with accommodations to meet his/her physical or other needs? [ ] YES [ ] NO

If yes, please list accommodations:_____

_____

If no, please complete the information below:

Diagnosis:_____

Summary of Therapeutic Plan to enable the student to return to school: _____

_____

Limitations, restrictions, or precautions the teacher should take in teaching this student:_____

_____

Is student's condition contagious? [ ] YES [ ] NO

I estimate this student will be homebound until (specific date required):_____

Physician's Signature_____ **Date**_____

Physician's Name (Print)_____ **Phone**_____

Fax_____

Address_____ **City**_____ **Zip**_____

RETURN TO PARENT/GUARDIAN
OR FAX TO: (209) 928-1422 ATTN: Attendance