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

PSYCHIATRIC 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 Psychiatrist must complete page 2 to authorize service

SUHSD USE ONLY:

Teacher Assigned: ____________________ Date Teacher Assigned: ________________

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

PSYCHIATRIC REFERRAL

This form is valid for current school year only.

Student Name: ____ **D.O.B.** ____________________

PSYCHIATRIST: 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.

Attending Psychiatrist's Statement

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

If yes, please list accommodations:____

____

If no, please complete the information below:

DSM IV Diagnosis:____

Summary of Therapeutic Plan: ____

____

What medication(s) is/are the student currently prescribed:____

____

Is the student a danger to self or others? [ ] YES [ ] NO

Why is the student unable to attend school?____

____

What aspects of the treatment plan are being implemented to enable the student to return to school:_______________

____

Estimated date student may return to school:____________________________________ [ ] Part time [ ] Full

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