HOME/HOSPITAL APPLICATION

Flow Chart: Processing Requests for Home/Hospital Instruction

Parent Notifies School That Student Has Temporary Disability

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Parent Completes Section I. Of Application Form, *"REQUEST FOR HOME/HOSPITAL INSTRUCTION"*

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Parent Has Physician/Clinical Psychologist Complete Medical Information

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Parent Returns Application Form to Attendance Clerk

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Attendance Clerk **Date Stamps Receipt of Form**, Completes School Information Section

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Original Form is Routed by Attendance Clerk to School Nurse Who Completes A Review Within 3 Days (Application Must Meet Criteria in EC 48206.3)

District has 5 Working Days *To Notify Parent of Acceptance or Rejection of Application*

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Completed Form with Site Administrator's Signature Submitted
To Pupil Services By
End of 3rd Working Day From Receipt
Faxes copy to Pupil Services Coordinator at (530-669-3212)

District has 5 Working Days *From Approval to Provide Instruction*

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Home/Hospital Administrator Has **2 Days** to Either

1. Reject the Application and Notify Parents
or
2. Approve the Application and Notify Parents

HOME/HOSPITAL APPLICATION

I. Parent and Student Information: To be filled out by parent/guardian

Student's Name (Last, First, MI) _____ Date of Birth/Age _____ Grade and Home School _____

Parent/Guardian's Name _____ Address _____

Primary language spoken at home _____ Home Phone _____ Cell Phone _____

Reason for Referral: _____

I give my permission for the exchange of confidential health information between Woodland Joint Unified School District and the recommending health care provider as it relates to the health condition and education planning for this child.

Parent/Guardian Signature _____ Date _____

II. School Information: To be filled out by school personnel. School should always consider whether other education options are more appropriate (ILC, Shortened Day, etc.).

1. School of Attendance: _____
2. Date of Last Attendance: _____
3. Recommended Home/Hospital teacher: _____ Name _____ Phone/Cell

Student is receiving the following services: (If student is on an IEP, a meeting must first be held to approve this placement option)

☐ IEP ☐ 504 ☐ Counseling ☐ Other : _____

Principal/Designee Signature _____ Date _____

School Nurse/School Psychologist/Counselor: Observations and/or recommendations (case description, possible modifications, and consultation with Physician/Psychiatrist/Clinical Psychologist. This must have comments from School Nurse and may also include School Psychologist/Counselor's comments: _____

Nurse or Psychologist/Counselor's Signature: _____ Date: _____

III. Pupil Personnel Services Review: To be completed by Pupil Personnel Services Department

☐ The student is approved for individual instruction through the Home/Hospital program

Instructor assigned: _____

Beginning date: _____ Ending date: _____

☐ Application Denied for the following reason: _____

Director's Signature _____ Date _____

cc: Counselor, Administration Revised 8/28/13

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IV. MEDICAL / MENTAL HEALTH INFORMATION – to be completed by Physician, Psychiatrist or Clinical Psychologist when application is for a physical, mental health, or emotional condition. School fills out top part and parent/guardian; please have Physician, Psychiatrist or Clinical Psychologist fill out bottom part. Please fill out completely and print clearly.

Dear Physician:

The parent/guardian of:

_____ _____
Student Name Date of Birth

has requested Home/Hospital instruction for their child during their illness. Home/Hospital instruction provides 5 hours a week of in-home instruction. ***This application must be renewed by medical verification every 6 weeks***.
Please complete this form and return it to:

_____ _____
School Nurse School Site

_____ _____
Phone Number Fax Number

Please complete the following:

_____
Today's Date

Diagnosis/Disabling Condition: _____

1. Is this a communicable disease? ☐ Yes ☐ No
   If yes, is condition transmitted via casual contact ☐ Yes ☐ No
   If yes, when is student no longer contagious? _____

   How does medical/emotional condition prevent school attendance? _____

   _____

2. Is school attendance possible with modifications: ☐ Yes ☐ No
   Explain: _____

   _____

3. Anticipated duration of home instruction: _____

4. Describe any necessary limitation of physical activity: _____

   _____

5. Any modifications for home instruction: _____

   _____

_____ _____
Signature of Physician, Psychiatrist or Clinical Psychologist Name of Physician, Psychiatrist or Clinical Psychologist

_____ _____
Mailing Address Phone Number/Fax Number