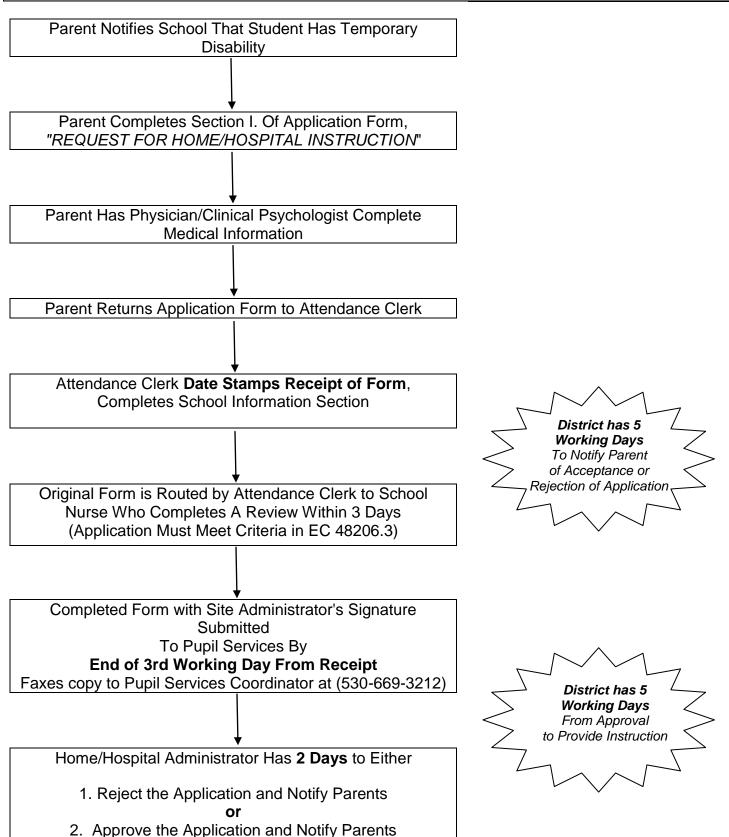


## HOME/HOSPITAL APPLICATION

## Flow Chart: Processing Requests for Home/Hospital Instruction





## **HOME/HOSPITAL APPLICATION**

I. Par	<b>ent and Student Information:</b> To be f	illed out by parent/guardian				
Stude	ent's Name (Last, First, MI)	Date of Birth/Age	Grade and Home School			
Parent/Guardian's Name Address						
Primary language spoken at home Home		Home Phone	Cell Phone			
Reas	on for Referral:					
-	my permission for the exchange of confider care provider as it relates to the health con		nd Joint Unified School District and the recommending ild.			
	·	·				
Parer	nt/Guardian Signature		Date			
	hool Information: To be filled out by spriate (ILC, Shortened Day, etc.).	chool personnel. School should alwa	ays consider whether other education options are more			
1	. School of Attendance:					
2	. Date of Last Attendance:					
3	Recommended Home/Hospital tead	Name	Phone/Cell			
Stude		es: (If student is on an IEP, a meeting m Other:	ust first be held to approve this placement option)			
Princi	pal/Designee Signature		 Date			
modi		sician/Psychiatrist/Clinical Psycho	mendations (case description, possible blogist. This <u>must</u> have comments from School			
Nurse or Psychologist/Counselor's Signature:			Date:			
III. Pu	ıpil Personnel Services Review: To b	pe completed by Pupil Personnel Ser	vices Department			
	The student is approved for individual instruction through the Home/Hospital program					
	Instructor assigne	ed:				
	Beginning date: _		Ending date:			
	Application Denied for the following	reason:				
Director's Signature			Date			



## **HOME/HOSPITAL APPLICATION**

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/guar	dian of:				
Student Name		Date of Birth			
home instruction	lome/Hospital instruction for their child during their il a. This application must be renewed by medical vertical of the third in the				
School Nurse		School Site			
Phone Number		Fax Number			
Please complet	te the following:				
Today's Date					
Diagnosis/Disab	ling Condition:				
1.	Is this a communicable disease? If yes, is condition transmitted via casual contact If yes, when is student no longer contagious?	☐ Yes ☐ Yes	☐ No ☐ No		
	How does medical/emotional condition prevent school attendance?				
2.	Is school attendance possible with modifications:  Explain:	Yes	□ No		
3.	Anticipated duration of home instruction:				
4.	Describe any necessary limitation of physical activity:				
5.	Any modifications for home instruction:				
Signature of Phy	ysician, Psychiatrist or Clinical Psychologist	Name of Physician, Psychiatrist or Clinical Psychologist			
Mailing Address		Phone Number/Fax Number			