Flow Chart: Processing Requests for Home/Hospital Instruction

1. Parent Notifies School That Student Has Temporary Disability
   - Parent Completes Section I. Of Application Form, "REQUEST FOR HOME/HOSPITAL INSTRUCTION"
   - Parent Has Physician/Clinical Psychologist Complete Medical Information
   - Parent Returns Application Form to Attendance Clerk
   - Attendance Clerk **Date Stamps Receipt of Form**, Completes School Information Section
   - 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)
   - 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)
   - Home/Hospital Administrator Has **2 Days** to Either
     1. Reject the Application and Notify Parents
     2. Approve the Application and Notify Parents

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

**District has 5 Working Days From Approval to Provide Instruction**
I. Parent and Student Information: To be filled out by parent/guardian

<table>
<thead>
<tr>
<th>Student’s Name (Last, First, MI)</th>
<th>Date of Birth/Age</th>
<th>Grade and Home School</th>
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<thead>
<tr>
<th>Parent/Guardian’s Name</th>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Primary language spoken at home</th>
<th>Home Phone</th>
<th>Cell Phone</th>
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**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.

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<th>Parent/Guardian Signature</th>
<th>Date</th>
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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: ____________________________

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<tr>
<th>Principal/Designee Signature</th>
<th>Date</th>
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**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: ____________________________

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<thead>
<tr>
<th>Nurse or Psychologist/Counselor’s Signature</th>
<th>Date</th>
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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: ____________________________

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<th>Director’s Signature</th>
<th>Date</th>
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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

cc: Counselor, Administration

Revised 8/28/13