Request for Home/Hospital Instruction Services

SECTION 1: STUDENT INFORMATION To be completed by parent/guardian.

Student Name:_____ ___M___F Date of Birth____/____/____ Grade_____

Address_____ City _____ Zip_____

Home Phone (____) _____ Mobile Phone/Parent (__) _____

Email Address _____ Mobile Phone/Student (__) _____

Parent/Guardian Name_____

Authorization to Receive/Release Medical and Academic Information for Educational Purposes. As the parent or legal guardian of the above named student and by my signature below, I authorize the Oakland Unified School District and the Physician identified on the reverse side of this form to release and exchange medical information relative to the above named student so eligibility for Home/Hospital (H/H) teaching services can be determined. I certify I am aware that I may request to review any requested records and may receive a copy of any materials exchanged. The information received will be used to assist the Oakland Unified School District in determining eligibility for Home/Hospital instructional services for the above named student. In the case that the above named student is accepted into the Home/Hospital Program, the information may be used, by the designated Oakland Unified School District instructor(s) for the purpose of tailoring an appropriate course of study for the student.

Please initial all of the following and sign below:

_____ I hereby request that my child be evaluated by OUSD for the Home/Hospital program because he/she is temporarily unable to attend school for medical reasons.

_____ I understand that placement in this program is at the discretion of OUSD.

_____ It is my intent that my child will return to his/her regular class(es) as soon as possible when his/her medical condition improves.

After my child has been evaluated, if it is determined that instruction will take place in the home:

_____ I agree to be present in the home or have a designated, responsible adult (18 years or older) in the home during all Home/Hospital services.

_____ I agree to provide a quiet and appropriate place for instruction.

_____ I agree to have my child ready for instruction as arranged with the H/H teacher.

_____ I agree to notify the teacher at least (2) two hours in advance if my child is unable to receive instruction for any reason.

X_____ _____ _____

Parent / Guardian Signature Relationship Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOLS

Completion of this document authorized the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

_____ _____

to provide health information from the above-named child's medical record to and from:

OUSD Home/Hospital Program . 746 Grand Ave. #4, Oakland, CA 94610 .

School District/Program to which disclosure is made **Address / City / State / Zip Code**

OUSD Home/Hospital Staff:
Director, Admin. Asst., H/H Instructors . . (510) 597-4294 Fax (510) 597-4296
Contact Person(s) at School District **Phone and Fax Number**

Disclosure of health information is required for the following purpose: educational planning .

Requested information shall be limited to the following:
☐ All minimum necessary health information; **or** ☐Disease-specific information as described:

_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ **(enter date)** or for one year from the date of signature, if no date entered.

RESTRICTIONS:

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____ _____ _____
Parent Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number

SECTION 2: PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PHYSICIAN* TREATING THE CHILD FOR THE MEDICAL CONDITION LISTED BELOW

*For psychiatric disorders, must be a psychiatrist or licensed clinical psychologist

Temporary Home instruction is provided to students unable to attend school for temporary reasons that are related to illness or injury. Students with long-term disabilities may be referred for special education evaluation. The California Education Code 44873 requires that a licensed California physician or licensed clinical psychologist provide written justification, including a medical diagnosis, indicating the extent to which the student can attend school.
Questions: Please call Home/Hospital Program 510-597-4294.

A. Diagnosis(es) Affecting Student's Ability to Attend School

Patient's Name	Diagnosis	ICD-9/10 Diagnostic Code

B. **Is this patient able to leave the home for reasons other than medical appointments?** ☐ Yes ☐ No

C. Indicate your placement request for this student.

☐ **Student may attend school, but only with modifications,** e.g. mobility supports, protection from infection from other students/staff, prn medications, proximity to toilet, emotional support, modified school hours.

Describe requested modifications:

_____

_____

☐ **I do not believe this student can attend any school site, even with extensive modifications.** I understand that I will be contacted by a member of the school district's team to discuss student's placement.

Describe reason(s) your patient is not able to attend school:

_____

_____

D. Plan for Student's Return to School.

Estimated date student may return to school _____/_____/_____

E. Physician Information

I am managing the care for this student _____Yes _____No

For psychiatric diagnosis: I am a psychiatrist or licensed clinical psychologist. _____Yes _____No

Physician Name (printed or stamp) License Number _____

_____ Phone(____)_____Fax(_____)_____

X_____ Date Signed_____

Signature of Physician

Section 3: SCHOOL INFORMATION To be completed school-of-record designee.

Student Name:_____ ___M____F Date of Birth ____/____/____ Grade_____

Last School Attended:_____ Last Date Attended: _____

Teacher / Counselor: _____ Grade: _____

Does this student have an IEP? ☐ Yes ☐ No If Yes, please attach a copy.

Does this student have a 504? ☐ Yes ☐ No If Yes, please attach a copy.

School program for Middle and High Students MUST be attached or filled in below.

PERIOD 1_____ PERIOD 4 _____

PERIOD 2_____ PERIOD 5 _____

PERIOD 3 _____ PERIOD 6 _____

Some courses may not be able to be replicated in the Home or Hospital environment.

Temporary Home instruction is provided to students unable to attend school for temporary reasons that are related to an illness or injury that prevents a student from attending class(es) at the regular school site. The expected period of absence must be at least twenty (20) school days. Students with long-term disabilities may be referred for special education evaluation.

I have reviewed this student's case.

_____
Signature of Principal / Designee