



REQUEST FOR HOME INSTRUCTION SERVICES

As part of Oakland Unified School District’s Home and Hospital Instruction Program, the District offers Home Instruction to students whose temporary disabilities make attendance in their regular school or program impossible or inadvisable.

Home Instruction provides 5 hours of individualized instruction per week in a manner consistent with California law. Home Instruction most often takes place in a student’s home, but may also take place in a public location, such as a library. While the District’s schools are closed to in-person instruction, HI will take place virtually (e.g., Zoom, FaceTime, or Google classroom) as appropriate and in accordance with District guidelines. Regardless of setting, an adult must be available for all teaching sessions.

In order to determine whether Home Instruction is right for a particular student, the District must review information provided by the student’s parent/guardian, the student’s medical provider, and the student’s regular school. Students with long-term disabilities may be referred for special education evaluation.

To Request Home Instruction:

Parent/guardian must complete the enclosed Parent/Guardian Request Form, and the medical provider must complete the enclosed Medical Provider Statement. Both forms must be returned to Gayle Buckles, Home and Hospital Program Manager, by email to gayle.buckles@ousd.org or by fax to 510-627-9064.



ALTERNATIVE EDUCATION – HOME/HOSPITAL PROGRAM

Parent/Guardian Request Form

Student Name: _____ Gender _____

Date of Birth _____ Primary language _____

Student Cell Phone (____) _____ Student Email address _____

Parent/ Guardian Name _____ Relationship _____

Address _____ City _____ Zip Code _____

Home Phone (____) _____ Parent Cell Phone (____) _____

Parent Email Address _____

Brief description of reason for Home Instruction request (i.e., how does the student's temporary disability make attendance in their regular school or program impossible or inadvisable):

School Information

School _____ Grade: _____ Last Date Attended: _____

Contact Person: _____ Phone: _____ Email: _____

Academic Programs/Services: General Education Classes AP Classes

Special Education/IEP Section 504



Parent/Guardian Consents/Agreements

Check the following:

- For each teaching session, I will be present in the home or ensure that a designated, responsible adult (18 years or older) is in the home
- I will ensure that my child has a quiet and appropriate place for instruction
- I will ensure that my child is ready for instruction, as arranged with the teacher
- I will notify the home teacher at least (2) two hours in advance if my child is unable to receive HI for any reason
- I agree that, from today's date through one year from today's date, the Oakland Unified School District may obtain, disclose, and/or exchange the following confidential information with the following medical provider:

Medical Provider

Name: _____

Address: _____ Phone/Email: _____

Type of Records

____ Medical Records ____ Educational Records ____ Medication information
____ Mental Health information ____ Physician Orders ____ Psychiatric Information
____ Immunization Records ____ Drug/Alcohol Information Other

By signing below, you indicate your understanding that California law prohibits OUSD from making further disclosure of your child's health information unless OUSD obtains another authorization form from you or unless such disclosure is specifically required or permitted by law. You understand that you may revoke this consent at any time by providing a written revocation, signed by you or on my behalf, and delivered to the health care agencies/persons listed above. You understand that your 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.

X _____
Parent / Guardian Signature Relationship Date



Medical Provider Statement

A request for home instruction has been made for the following student. In order to assess this request the Oakland Unified School District requests a statement from a licensed California physician (in the case of psychiatric disorders, this physician must be a psychiatrist or licensed clinical psychologist), including a medical diagnosis, indicating the reason that the student is unable to attend their regular school program. Chronic conditions may not qualify. I understand that I may be contacted by a member of the school district's team to discuss student's placement.

Student Name _____ Date of Birth _____

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

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

Indicate your placement request for this student:

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

Recommended Modifications: _____

- I do not believe this student can attend any school site, even with extensive modifications.**

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

Estimated date student may return to school _____

Medical Provider 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 Medical Provider