EAST SIDE UNION HIGH SCHOOL DISTRICT

830 North Capitol Avenue, San Jose, CA 95133 | 408.347.5331 | esuhsd.org

Preparing every student to thrive in a global society.

APPLICATION FOR HOME/HOSPITAL INSTRUCTION – MEDICAL

(Do not use this form for Psychiatric conditions)

Student Last Name	**Student First Name**	**School of Attendance**
Date of Birth	**Student Language**	**Parent/Guardian Language**
Address		
Home Phone	**Cell Phone**	**Work Phone**
Parent Name		**Does Student have a current IEP?** Yes No

The following alternative programs or other educational options have been attempted (please check all options that apply):

- Student school day shortened
- Student has applied for/has been enrolled in an Independent Study Program
- Site team has developed and implemented a 504 Accommodation Plan; Date of 504: ____________________
- Site team has developed an Instructional Support Team (IST); Date of IST: ____________________________
- Other: ____

IMPLEMENTATION OF SERVICE

If approved, Home/Hospital Instruction will provide five (5) hours of instruction per week in a manner consistent with California laws. A responsible adult (18 years of age or older) <u>must</u> be present when the teacher is in the home.

By signing this authorization for service, the parent/guardian is agreeing to the following:

- I understand that Home/Hospital Instruction is not intended as a general program of independent study, but a temporary program for students with a *temporary* medical or psychiatric disability which prevents attendance in a regular day or alternative education programs, even with accommodations or modifications.
- If the student is eligible, educational services will be coordinated by ESUHSD Student Services.
- The student will be temporarily dis-enrolled from their regular school of attendance during the period they are receiving home instruction. Grades will be reported to the school of attendance by the Home/Hospital instructor.
- In order to remain eligible for HHI, student agrees to participate in scheduled meetings with the instructor and to complete all work assigned.
- Educational information will be accessed and used to plan and provide an appropriate educational program for the student.

Parent/Legal Guardian authorization to receive/release academic information and temporarily transfer educational duties:

Student Signature ____ **Date** ________________________

Parent Signature ____ **Date** ________________________

Updated 7/19/19

➔Parent: Send completed *Application for Home/Hospital Instruction* to **ESUHSD Student Services**

ESUHSD APPLICATION FOR HOME/HOSPITAL INSTRUCTION – MEDICAL

HIPPA PRIVACY AUTHORIZATION
FOR RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS

Student Last Name	**Student First Name**	**School of Attendance**
Date of Birth	**Home Phone**	**Medical Record Number**
Address		

Person/Organization Information Will Be Requested From:	**District Authorized Representative Information Will Be Sent And/Or Disclosed To:**
Name:	Name: East Side Union High School District
Address:	Address: 830 N. Capitol Avenue
City/State/Zip:	City/State/Zip: San Jose, CA 95133
Phone:	Phone: (408) 347-5331
FAX:	FAX: (408) 347-5335

Information requested to be released:
(Parent/Guardian to initial)

☑ Medical records and information ________

☑ Exchange of written or verbal information between the organizations listed above ________

Other records (Specify) ____

Description of purpose for the use of release of the information:

For Home/Hospital Instruction application

Updated 7/19/19

ESUHSD APPLICATION FOR HOME/HOSPITAL INSTRUCTION – MEDICAL
HIPPA PRIVACY AUTHORIZATION
FOR RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS (continued)

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: ____.

I understand that the District Authorized Representative shall have full authority to request and receive information in regards to my child as stated above and within the effective timeline. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the school district representative requesting the information. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

I understand that health information used or disclosed pertaining to this authorization may be subject to redisclosure by the receiving organization and that the information requested may no longer be protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

I consent to the release of the information indicated above and acknowledge that I have received a copy of this release. A copy of this authorization is considered valid.

____ _________________________
Student Signature **Date**

____ _________________________
Parent* Signature **Date**

"Parent" may refer to any person having legal custody of the Student (e.g., biological, adoptive, or foster parents); any adult student without a guardian or conservator; a person acting as the child's parent if neither the parent nor guardian can be notified of the educational actions under consideration; or an appointed surrogate parent. "Parent" does not include a nonpublic, nonsectarian school or agency under contract with LEA. (EdCode 56028)

I, ____, have read the above as related to designation of District Authorized Representative and I hereby accept this designation as District Authorized Representative for the following student: ____ .

____ _________________________
Signature of District Authorized Representative **Date**

ESUHSD MEDICAL VERIFICATION FORM FOR HOME/HOSPITAL INSTRUCTION
MEDICAL REFERRAL

Student Last Name	Student First Name	Date of Birth
Address		**Phone**

Physician, Physician Assistant or Nurse Practitioner: A request for temporary Home/Hospital Instruction has been made for the above-named student. This referral form must be completed by a California licensed physician, physician assistant, or nurse practitioner in order to be considered for the service and must include a diagnosis and the length of time the student is anticipated to be confined. Chronic conditions may not qualify.

PHYSICIAN'S STATEMENT (to be completed by a California licensed physician, physician assistant, or nurse practitioner)

Is student physically capable of attending classes on his/her school campus now, with accommodations to meet their physical or other needs? Yes No

If yes, please list accommodations:

If the student is able to attend school with accommodations, then this will be considered before Home Hospital Instruction.

If no, please complete the information below:

Diagnosis (Including student limitations or restrictions)

Is this a chronic health condition? Yes No

Prognosis

Is this student pregnant? Yes No **If yes, expected due date:** _______________

Updated 7/19/19

ESUHSD Medical Verification Form for Home/Hospital Instruction
Medical Referral (continued)

Summary of Treatment Plan (please outline plan of care and include aspects of the treatment plan that are being implemented to enable the student to return to school)
Current medications
Precautions the teacher should take in instructing this student, if applicable
Estimated date of return to school (Must be for a minimum of 3 weeks)

- I verify the student has no contagious disease or other medical condition that poses a risk to District staff.
- I verify that the student's health allows for completion of assignments, but the student is confined to home or hospital.
- I understand that placement of this student on Home/Hospital Instruction is at the discretion of ESUHSD.
- If further information is requested by ESUHSD, a *delay in response or an incomplete application may result in delay of approval for Home Hospital Instruction*.

Please provide contact information where you may be reached directly for further questions, if necessary.

Signature ____ **MD** **Date** ____________________________

Print Name____ **Phone** ____________________________

Address ____ **FAX** ____________________________

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Updated 7/19/19