**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 – PSYCHIATRIC

*(Do not use this form for Medical 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 up to five (5) hours of instruction per week in a manner consistent with California Education Code (*EC48206.3, EC48207, EC48208*). A responsible adult (18 years of age or older) must be present when the instructor 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 program for students with a *temporary* medical or psychiatric disability which prevents attendance in a regular day or alternative education program, 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** _____

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

**ESUHSD APPLICATION FOR HOME/HOSPITAL INSTRUCTION – PSYCHIATRIC**

**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)**

☑ Psychoeducational evaluations/records _____

☑ Mental health 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

**ESUHSD APPLICATION FOR HOME/HOSPITAL INSTRUCTION – PSYCHIATRIC**
**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. (*EC56028*)

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**
**PSYCHIATRIC REFERRAL**

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

**Psychiatrist**: 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 psychiatrist 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 to the home.

**PSYCHIATRIST'S STATEMENT** (to be completed by a California licensed psychiatrist)

Is student capable of attending classes on his/her school campus now, with accommodations to meet their emotional 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:

| **DSM-V Diagnosis** |
|---|
| **Summary of Treatment Plan** (please outline plan of care) |
| **What are the current medications?** |
| **Is the student a danger to self or others?** ☐ Yes ☐ No<br>Explain: |

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

| **Why is the student unable to attend school?** |
|---|
| **What aspects of the treatment plan are being implemented to enable the student to return to school?** |
| **Estimated date of return to school** (Must be for a minimum of 3 weeks) |

- In the case of an emotional, psychological or behavioral diagnosis, I verify that this student is receiving continuing professional care with a goal of returning to a less restricted learning environment as soon as possible.
- I verify that the student's mental 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** _____

_____

_____