

A COPY OF IMMUNIZATION RECORDS SHOULD ACCOMPANY THIS REFERRAL

HOSPITAL MEDICAL REFERRAL

Carlson Home Hospital School
10952 Whipple St., No. Hollywood, CA 91602

<u>Student Information</u>	
Last Name _____	First Name _____ <input type="checkbox"/> M <input type="checkbox"/> F
DOB ___/___/___ Gr. ___	Student Language _____ Parent/Guardian Language _____
Address _____	City _____ Zip _____
Home Phone () _____ - _____	Cell Phone () _____ - _____
Parent/Guardian _____	Work Phone () _____ - _____
Parent Email Address _____	Student Email Address _____
School of Attendance _____	Last date of attendance at current School ___/___/___
Does student have a current IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No Eligibility _____ 504 Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CARLSON HOSPITAL TEACHER: _____ **SITE NAME:** _____

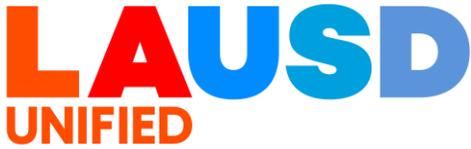
IMPLEMENTATION OF SERVICE

HOSPITAL TEACHING - Hospital Instruction will be provided in a manner consistent with California laws governing home hospital teaching. Instruction is offered in two (2) basic subject areas unless additional courses are approved by a Carlson administrator.

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

- If the student is eligible, educational services will be temporarily provided by the Carlson Home Hospital School.
- The student will be temporarily disenrolled from his/her regular school of attendance (cumulative record carrying school) during the period he/she is receiving home instruction. Grades and marks will be reported to the cumulative record carrying school.
- Educational information will be accessed and used to plan and provide an appropriate educational program for the student.
- Permission to provide services or access school records may be revoked via written parent/guardian request at any time.
- Carlson provides hospital instruction between the hours of 8:00 a.m. and 3:00 p.m.

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION AND TEMPORARILY TRANSFER EDUCATIONAL DUTIES:	
Parent Signature _____	Date ___/___/___



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Student Name _____ D.O.B. ____/____/____

PHYSICIAN: A request for Hospital Instruction has been made for the above-named student. If educational services are authorized at this time, please complete, sign below and return this form to the Hospital Teacher or Carlson Office.

Attending Physician's / Psychiatrist's Statement

Diagnosis for ICD/DSM Code: _____

Summary of Medical Problem/Therapeutic Plan: _____

Precautions/Restrictions applicable for bedside/classroom teaching:

Is student in ICU? Yes or No **In Isolation?** Yes or No

This section to be completed by a California licensed physician or psychiatrist:	
Admission Date ____/____/____	Estimated Discharge Date ____/____/____
Signature _____ MD	Signature Date ____/____/____
Print Name _____	Phone () ____ - ____
Print Title _____	Fax () ____ - ____
Address _____	City _____ Zip _____

Is student's condition contagious? Yes or No