

A COPY OF IMMUNIZATION RECORDS ARE REQUIRED WITH THIS REFERRAL

HOME MEDICAL REFERRAL

Carlson Home Hospital School

10952 Whipple St., No. Hollywood, CA 91602
Phone: (818) 509-8759 FAX: (818) 505-0246

Student Information

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

IMPLEMENTATION OF SERVICE

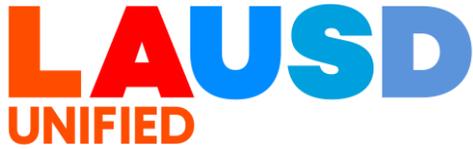
Face-to-Face Home Instruction will provide students in grades TK–5/6 on the General Ed Curriculum or in grades TK–12 on the Alternate Curriculum five (5) hours of instruction per week. Instruction is offered in two (2) basic subject areas. English Learners and Standard English Learners will be provided additional instruction in ELD/MELD. A responsible adult (18 years of age or older) identified in writing by educational rights carrier must be present when the teacher is in the home.

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 Carlson services. Grades and marks will be reported to the cumulative record carrying school.
- Permission to provide services or access school records may be revoked via written parent/guardian request at any time.
- Carlson provides home instruction between the hours of 8:00 a.m. and 7:00 p.m.
- California Licensed Health Care Provider must complete page 2 to authorize service

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, DOCTOR OF OSTEOPATH, PHYSICIAN ASSISTANT, OR NURSE

PRACTITIONER: A request for temporary Home Instruction has been made for the above-named student. This referral form (page 2 of 2) must be completed by a California licensed MD, DO, PA, or NP in order to be considered, and must include a diagnosis and the length of time the student is anticipated to be confined. **Chronic conditions** may not qualify.

DO NOT USE THIS FORM FOR PSYCHIATRIC CONDITIONS. (USE ATTACHMENT C).

Attending Health Care Provider’s Statement

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

If yes, student does NOT qualify for home instruction. List accommodations to be used at the student’s current school campus:

If no, complete the information below:

Diagnosis:

Summary of Therapeutic Plan to enable the student to return to school:

Limitations, restrictions, or precautions the teacher should take in teaching the student:

Is student’s condition contagious? Yes or No

This section to be completed by a licensed physician, osteopath, physician’s assistant, or nurse practitioner:		
Estimated date student may return to school (<i>Specific</i> date required)		
Signature	MD, DO, PA, NP (circle one)	Date
Print Name	Phone	
Print Title	Fax	
Print name of supervising physician		
Address	City	Zip