OXNARD UNION HIGH SCHOOL DISTRICT
High Expectations and Powerful Futures for *Every* Student

HOME OR HOSPITAL INSTRUCTION

☐ **Physician's Request** ☐ **Psychiatrist's/Licensed Mental Health Provider's Request**

Parent/Guardian: Please complete *Student Information* area below, with both parent and student signatures. The student's physician or mental health provider **must complete the center OR bottom portion, depending on the recommendation**. Return completed form to your child's counselor or school nurse in order to begin services.

Student Information

Name _____ M F DOB ___/___/___ Gr. _____ Student ID # _____
Address _____ City _____ Zip _____
Parent/Guardian_____
Home Phone _____ Cell Phone _____ Work Phone _____
School _____ Last Date of Attendance _____
A) Does the student have a Section 504 Plan? Yes No, **B)** Does student have a current IEP? Yes No, **C)** Is the student in foster care or McKinney Vento? Yes No, **D)** Is the student an English Learner? Yes No

PARENT/LEGAL GUARDIAN/STUDENT AUTHORIZATION TO 1) RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION, 2) TEMPORARY TRANSFER OF EDUCATIONAL DUTIES, 3) HOME/HOSPITAL TEACHING INSTRUCTION CONTRACT AND PARENT/STUDENT RIGHTS.

PHYSICIAN/PSYCHIATRIST

I recommend this student for Home/Hospital Instruction beginning_____and ending _____.

For a modified program recommendation:
Would modification of this student's school day meet their needs? Yes No
If YES, suggested modifications:_____
_____
Physician/Mental Health Provider Signature _____ Date _____
Physician/Mental Health Provider Signature (Print) _____ Phone_____
FAX _____Address _____ City _____
ZIP_____

OR-

PHYSICIAN/PSYCHIATRIST

A request for Home/Hospital Instruction has been made for the above-named student. We require that a licensed California physician or Psychiatrist file a statement which includes a medical diagnosis to the extent that the student is temporarily unable to attend classes (CEC 48206.3). If educational services are recommended at this time, please complete, sign below and return to the student's parent. *Minimum 4 weeks*

Attending Physician's/Psychiatrist's/Mental Health Provider's Statement

Diagnosis/Summary of Medical or Mental Health issue:_____
_____
Impact on student's ability to attend school:_____
_____
Is student now hospitalized? Yes No If Yes, where? _____
Anticipated Discharge Date: _____Is student contagious? Yes No
Physician/Mental Health Provider's Signature _____
Date _____
Physician's/Mental Health Provider's Name (Print)_____
Phone:_____ FAX: _____
Address_____ City _____ ZIP _____

Parent/Student Information

- Home/Hospital Instruction is a program that provides educational services for students who are **temporarily** disabled by accident and unable to attend school, or by physical, mental or emotional illness.
- It is a **short-term** placement and shall be provided only when a student is expected to be out of school a minimum of four (4) weeks, not to exceed a semester unless medically fragile/extended mental health treatment.
- This service is provided either in the home, or hospital, or residential health facility within the district.
- Such instruction is given from one to five (5) hours a week.
- The home teacher will not instruct a pupil unless parent or guardian is in attendance.

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When Home/Hospital Instruction is authorized, you are certifying that the illness/injury is significantly severe the student is unable to attend on-site school instruction. You understand that your responsibilities to the home/hospital instruction program are:

1. To keep established appointments
2. To notify teacher if appointments cannot be kept
3. To complete all assignments
4. To provide the school nurse with physician clearance for return to school
5. Failure to comply with the terms of this contract may result in loss of credit.

(CEC 48206.3; OUHSD Board Policy (BP) 6183, Section 6000- Instruction)