POWAY UNIFIED SCHOOL DISTRICT
Alternative Programs
13626 Twin Peaks Road
Poway, CA 92064

2011-12 School Year

Dear Parent:

In order to obtain home instruction for your child, the following forms must be completed and returned to the school site:

- **REQUEST FOR HOME AND HOSPITAL INSTRUCTION**

- **PHYSICIAN'S STATEMENT REQUESTING HOME AND HOSPITAL INSTRUCTION**

- **AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION**

- **IF YOUR CHILD HAS AN IEP, A CHANGE OF PLACEMENT MEETING MUST BE HELD AND HOME/HOSPITAL APPROVED FOR THE NEW INSTRUCTIONAL SETTING – A COPY OF THE NEW IEP AND MEETING NOTES MUST ACCOMPANY YOUR APPLICATION.**

The home tutor will contact you to arrange for the first visit as soon as the school site receives these forms. Please arrange your time accordingly so that you will be able to make contact with the home tutor. You will be responsible for monitoring the days and times when the home tutor will work with your child. A clear and quiet workplace for the home tutor and your child is requested. Please note that before your student may be readmitted to his/her school, the enclosed form **PHYSICIAN'S RELEASE FROM HOME AND HOSPITAL INSTRUCTION** must be signed by your physician and returned to the school site.

Your application, once approved, is only valid for the current school year. You will need to reapply each school year, in the event the illness is prolonged over multiple school years.

Please contact me if I can be of any further assistance during this difficult time.

Sincerely,

Martha Parham
Director of Alternative Programs

/lla
Enclosures (4)

POWAY UNIFIED SCHOOL DISTRICT
13626 Twin Peaks Road, Poway, CA 92064-3034
(858) 748-0010, Ext. 2723 ● FAX (858) 679-2630

REQUEST FOR HOME AND HOSPITAL INSTRUCTION

ALTERNATIVE PROGRAMS

2011-2012

Date of Request_________________ Birth date_______________Phone___________________

Student's Full Name____
First Middle Last

Residence Address____
Street City/State/Zip

Parent's Email Address____

School________________________ Grade____________ Home Language:_______________

Teacher ____________________________ Counselor __________________________

Does your student receive special services? ☐ GATE ☐ 504 ☐ Special Ed (IEP) ☐ RSP (IEP)

(504 OR IEP MUST BE ATTACHED TO APPLICATION)

Reasons for Request:
____
____

Brief History of Disability:
____
____
____

Probable Duration of Disability____

Last date of school attendance____

Areas in which student needs special help____
____

Student's special interests____

Signature of Parent/Guardian____

- -

DISTRICT OFFICE USE ONLY

Tutor Assigned____

Date______________________________ Date Released___________________________

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AUTHORIZATION FOR RELEASE / EXCHANGE OF INFORMATION

POWAY UNIFIED SCHOOL DISTRICT 13626 TWIN PEAKS ROAD, POWAY, CA 92064

To: ____ (Physician name)

____ (Office/Specialty)

____ (Address)

_________________________/__________________ (Phone/Fax)
(area code)

I hereby request and authorize you to release any relevant medical, social, psychological, and/or test information you may have, or may receive pertaining to:

______________________________	________________	________________
(STUDENT'S NAME)	(BIRTHDATE)	(SCHOOL)

The disclosure of this information is required for the following purpose (s):

HOME/HOSPITAL PROGRAM APPROVAL/VALIDATION/UPDATES

____

I understand that this consent is valid for one (1) year from the date of signing and that I may revoke this consent, at any time, by notification in writing to either of the named agencies and this revocation shall apply to both agencies.

Please direct information to: Attention of Martha Parham, Director of Alternative Programs
Poway Unified School District
13626 Twin Peaks Road
Poway, CA 92064-3034
(858) 679-2531 ● FAX (858) 679-2630

I understand that I may request a copy of this authorization for personal records.

____
(SIGNATURE)

____
(RELATIONSHIP TO STUDENT)

____
(DATE)

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13626 Twin Peaks Road, Poway, CA 92064-3034
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PHYSICIAN'S STATEMENT REQUESTING HOME AND HOSPITAL INSTRUCTION
2011-2012

To: Physician

We are allowed by law to provide educational services to homebound or hospitalized students only on authorization of a **licensed physician**. **Please note that the State of California only allows *5 HOURS of service each week – thus this program should only be used as a temporary and last resort.*** This service will be continued as long as the pupil is under continued medical care and is considered to be unable to return to school. *The District depends upon you to notify us when the pupil's condition has improved sufficiently for him/her to return to school.*

For your convenience, we have prepared the form below, which will give us the information we need. This form must be resubmitted each school year ONLY if illness requires Home/Hospital. Thank you.

Date: ___________________________

Name of Student: ____DOB: ___________________

The above named student is unable to attend regular school classes, but is ready and able to have home tutoring. My medical findings and recommendations are as follows:

Diagnosis: ____

I estimate this student will be homebound until: _______________________________________
(Please give *specific* date.)

In order to protect the Home/Hospital tutor, who is instructing in the patient's home, please mark one of the below statements, and sign below:

☐ Patient **IS** a danger to the Home/Hospital Tutor

☐ Patient is **NOT** a danger to the Home/Hospital Tutor

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

____

Remarks: ____

Physician: _____________________________ Signature: _____________________________
(print name)

Address: _____________________________ Telephone: _____________________________

_____________________________ License No.: _____________________________

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PHYSICIAN'S RELEASE FROM HOME AND HOSPITAL INSTRUCTION 2011-2012

This form **must be completed and signed by the physician** *and presented to the Alternative Programs Department and confirmed* **before** *the student will be readmitted to class.*

Please readmit ____ to his/her regular school or
Student's Name

classroom setting, effective: ______________________________.
Date

My recommendations for this student are:

Regular School Program ______

Rest in bed at school for ______ hours

Restricted activities ______ please specify: ____________________________

____

Other: ____

The above recommendations will be followed until further communication from the physician is received.

Comments:

Physician Signature____ Date_____________

Physician Name (Please Print)____

Address ____

Phone ______________________________ Fax________________________________
(area code) (area code)

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