Health Services Department, Sacramento City Unified School District

Home Hospital Instruction (HHI) or Medical Independent Study (MIS)

Parent Request (Form A)

If your student has an IEP, please STOP and contact the Special Education Department.

SCUSD offers Home Hospital Instruction (HHI) and Medical Independent Study (MIS) as services to meet the educational need of students who incur a temporary but extended illness or disability which makes attendance at their regular school impossible or inadvisable. The expected period of absence must be **at least six(6) weeks**.

The goal of each service is to maintain the student's *former* level of performance while recovering.

"Temporary disability" (Ed Code 48206.3) is defined as a physical, mental, or emotional disability incurred while a pupil is enrolled in regular day classes or an alternative education program, and after which the pupil can reasonably be expected to return to regular day classes or the alternative education program without special intervention. A temporary disability shall not include a disability for which a pupil is identified as an individual with exceptional needs pursuant to Ed Code 48207.

Student's Name:_____ Birthdate: _____ Grade: _____ Gender: _____

Parent(s) /Guardian(s) Name(s):_____

Home Address: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

E-mail: _____

Current School: _____ Current Teacher: _____

Please initial all of the following and sign below:

_____ I hereby request that my child be evaluated by SCUSD for the Medical Independent Study or Home Hospital Instruction program because he/she is temporarily unable to attend his/her school for medical reasons.

_____ I understand that placement in these programs is at the discretion of SCUSD.

_____ I agree to attend planning/placement meetings.

_____ It is my intent that my child will return to his/her regular class(es) as soon as possible when his/her medical condition improves.

_____ I understand that prior to returning to his/her home school, a release from his/her doctor stating that he/she is ready to return to full time attendance must be obtained and submitted to Health Services. This notice must include any limitations that may still exist.

_____ I understand that if my child wishes to participate in any school based activities or end-of-year/graduation activities, a physician's release to participate (along with any restrictions or parameters) must be submitted to Health Services no less than six(6) weeks in advance.

After my child has been evaluated, if it is determined that instruction will take place in the home:

_____ I agree to be present in the home or have a designated responsible adult present in the home during all MIS or HHI services.

_____ I agree to provide a quiet and appropriate place for instruction.

_____ I agree to have my child ready for instruction as arranged with the teacher.

_____ I agree to notify the teacher as far ahead as possible if my child is unable to receive instruction for any reason.

**Parent/Guardian Signature:* _____ *Date:* _____

 Return this completed form to HomeHospital@SCUSD.edu or fax to (916) 399-2028

Authorization for the Use or Disclosure of Health Information to School Districts (Form B)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name:

_____/_____

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

to provide health information from the above-named child's medical record to and from:

Sacramento City USD Health Services Department — School District to which disclosure is made

5735 47th Avenue Sacramento, CA 95824 — Address/City & State/Zip Code

Home Instruction Coordinator/Credentialed School Nurse — Contact person at School District

(916) 643-9412 — Area code and Telephone Number

The disclosure of health information is required for the following purpose:

To evaluate the student and determine the need for services.

Requested information shall be limited to the following: ☐ All health information; or

☐ Disease-specific information as described: _____

_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

Return this completed form to HomeHospital@SCUSD.edu or fax to (916) 399-2028

Authorization for the Use or Disclosure of Health Information to School Districts (Form B)

RESTRICTIONS:

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's permanent educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least, restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Printed Name	Signature	Date

Relationship to student	Area code and Telephone Number

H.F. 19

Return this completed form to HomeHospital@SCUSD.edu
or fax to (916) 399-2028

Health Services Department, Sacramento City Unified School District

Home Hospital Instruction (HHI) or Medical Independent Study (MIS)

Physician Request (Form C)

Dear Medical Provider,

SCUSD offers Home Hospital Instruction and Medical Independent Study as services to meet the educational need of students with an acute condition that prevents attendance at their regular school. "Temporary disability" (Ed Code 48206.3) is defined as a physical, mental, or emotional disability incurred while a pupil is enrolled in regular day classes or an alternative education program, and **after which the pupil can reasonably be expected to return to regular day classes or the alternative education program without special intervention.** A temporary disability shall not include a disability for which a pupil is identified as an individual with exceptional needs pursuant to Ed Code 48207.

Please complete the following to assist us in determining how to best meet the academic needs of your patient.

Our programs require a minimum expected absence of six(6) weeks.

Expected duration of Absence: Beginning date: _____ ***(MM/DD/YR)*** **End date:** _____ ***(MM/DD/YR)***

Student's Name:_____ Birthdate: _____

Medical diagnosis: _____

If emotional, psychological, or behavioral, is this student receiving ongoing medical care? ☐ Yes ☐ No

Prognosis:_____

Date(s) of Medical/Psychiatric Examination: _____

Location and Duration of Hospitalizations: _____

Medications: _____

Physical limitations preventing school attendance: _____

_____

Psychological or emotional limitations preventing school attendance: _____

_____

Recommendations for physical/psychological accommodations upon return to school:_____

_____

This is to certify that the student named above is in my professional care. This student does not have a contagious disease that will endanger the health and safety of the teacher. I understand that placement of this student in Home Hospital Instruction or Medical Independent Study is at the discretion of SCUSD.

_____ _____

Physician's Signature Date

Physician's Name: _____ Phone: _____

Hospital Affiliation: _____ Fax: _____