LOS ANGELES UNIFIED SCHOOL DISTRICT
Educational Options

Carlson Home Hospital School

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

HOME MEDICAL REFERRAL

Student Information

Name_____ ☐ M ☐ F DOB_____/_____/_____ Gr. _____ Student Language_____

Address_____ City_____ Zip_____

Home Phone( ) _____ Cell Phone( ) _____ Work Phone( ) _____

Parent/Guardian _____ Parent/Guardian Language _____

Cum Carrying School _____ Phone( ) _____ Track ____ Local District _____

Last date of attendance _____

Does student have a current IEP/504 Plan? ☐Yes ☐ No Eligibility_____

IMPLEMENTATION OF SERVICE

HOME TEACHING Carlson Home Instruction will provide five (5) hours of instruction per week in a manner consistent with California laws governing home teaching. Instruction is offered in two (2) basic subject areas unless additional courses are approved by a Carlson administrator. A responsible adult (18 years of age or older) 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 home instruction or teleteaching. 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.
- The parent/guardian has the right to receive a copy of this form upon request.

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION AND TEMPORARILY TRANSFER EDUCATIONAL DUTIES:

Parent Signature_____ Date: _____

California Licensed Physician must complete page 2 to authorize service

HOME MEDICAL REFERRAL

Student Name _____ **D.O.B** _____

PHYSICIAN: A request for Home Instruction has been made for the above-named student. The California Education Code §44873 requires that a licensed California physician file a statement which includes a medical diagnosis to the extent that the student is unable to attend classes on any school campus. **DO NOT USE THIS FORM FOR PSYCHIATRIC CONDITIONS (USE ATTACHMENT C).**

Attending Physician's Statement

Diagnosis:_____

_____

Summary of Medical Problem:

_____

_____

_____

Please note restrictions, if any (ie: use of stairs, bathroom needs, Physical Education participation, length of day, etc.): _____

_____

_____

Is student's condition contagious? ☐ Yes ☐ No

Is student physically capable of attending classes on his/her school campus now? ☐Full-time ☐Part-time ☐No

Estimated date student may return to a school campus: _____ ☐Full-time ☐Part-time

Physician's Signature _____ **Date**_____

Physician's Name (Print) _____ **Phone:** ( ) _____

FAX: ( )_____

Address_____ **City**_____ **Zip** _____