

Ceres Unified School District
Home & Hospital Instruction Application Form

PUPIL DATA (to be completed by school personnel)

School Site _____

Student Name _____	Date of Birth _____	Gender _____
Parent or Guardian _____	Home Phone _____	
Address _____	Cell Phone _____	
Grade _____	Special Ed? Yes _____ No _____	Special Ed Case Manager/Teacher _____
Language(s) Spoken in Home _____	English _____	Other (please specify) _____
		Last Day of School Attendance _____

PARENT AUTHORIZATION (to be signed by parent or legal guardian before forwarding to physician)

I hereby authorize Dr. _____ to release medical and other confidential information to Ceres Unified School District.	
_____ Signature of Parent or Legal Guardian	_____ Date

PHYSICIAN REPORT (to be completed by physician)

<i>Information to Physician: Instruction in the home is one of the most restrictive educational placements available and must be viewed as the placement of the last resort to be utilized for the shortest time necessary. Your careful completion of the following information will assist the school to determine whether we can make adaptations for the pupil. Thank you for your assistance.</i>			
What is your professional relationship to this pupil?	Family Physician _____	Clinic Physician _____	Consultant/Specialist _____
What is the diagnosis for this pupil?	_____		
What treatment is being prescribed?	_____		
Please specify the procedures/surgery anticipated:	_____		
Can pupils needs be served by making adjustments or adaptations, at the school site, to accommodate the special needs of this pupil?	Yes _____	No (please explain why): _____	
If Home & Hospital is NOT indicated, please check ANY ADAPTATIONS THAT ARE APPROPRIATE FOR THIS PUPIL:			
Rest/Snacks _____	Medication _____	Modified Furniture _____	Modified Education _____
Shorten School Day _____	Reduced Walking (i.e., modify class scheduled) _____	Other (please specify) _____	
CERTIFICATION:	is it medically advisable for this pupil to attend school with the adaptations checked above?	Yes _____	No _____
CERTIFICATION:	is it medically advisable for this pupil to be placed on Home & Hospital Study?	Yes _____	No _____
Length of Absence from School?	_____ Weeks _____	Months (up to 3 months) _____	Reevaluation Date _____
Comments:	_____		
Can the pupil return to school without an additional doctors note?	No _____	Yes _____	If so, when? _____
Physician's Name (print please)	_____	Specialty:	_____
Physician's Address	_____	Phone #:	_____
Physician's Signature:	_____	Date:	_____