

LOS ANGELES UNIFIED SCHOOL DISTRICT
Division of Special Education
Carlson Home Instructional Program and Hospital School

MEDICAL REFERRAL FOR HOSPITAL INSTRUCTION
FOR HOSPITAL USE ONLY

HOSPITAL TEACHER: _____
Print Name Print Site

When completed by the student's physician, attach to the Student Information Form and send to the Carlson office.
Do not enroll any student prior to completion of this form.

HOSPITAL NURSE: Please complete *Patient/Student Information* area below and give to the student's physician for completion.

Patient/Student Information

Name _____ ☐ M ☐ F DOB ____/____/____ Gr. ____ 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 the student have a Section 504 Plan? ☐ Yes ☐ No

Does student have a current IEP? ☐ Yes ☐ No Eligibility _____ Review Date ____/____/____

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION:

Parent Signature _____ Date _____

(See reverse side for explanation)

PHYSICIAN: A request for Hospital 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. If educational services are authorized at this time, please complete, sign below and return this form to the Hospital Teacher.

Questions: Call the School Nurse, Carlson Home Instructional Program and Hospital School at (818) 509-8759

Attending Physician's Statement

Diagnosis: _____

Summary of Medical Problem/Therapeutic Plan: _____

Precautions/Restrictions applicable for bedside/classroom teaching: _____

Is student contagious? ☐ Yes ☐ No Is student: ☐ Inpatient ☐ Outpatient

Admission date: _____ Anticipated Discharge date: _____

Physician's Signature _____ M.D. Date _____

Physician's Name (Print) _____ M.D. Phone: (____) _____

FAX: (____) _____

Address _____ City _____ Zip _____