

MEDICAL REFERRAL FOR HOME INSTRUCTION/TELETEACHING

SCHOOL: Please complete *Student Information* area below and send to the student's parent/legal guardian for completion by the student's physician. Include a return envelope addressed to: School Nurse, Carlson Home Instructional Program and Hospital School, 10952 Whipple St., No. Hollywood, CA 91602. Phone: (818) 509-8759 FAX: (818) 505-0246.

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 AND TEMPORARY TRANSFER OF EDUCATIONAL DUTIES:

Parent Signature _____ Date _____
(See reverse side for explanation)

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. If educational services are authorized at this time, please complete, sign below and return this form via U.S. Mail in the enclosed envelope or FAX to: (818) 505-0246.

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: _____

What aspects of the therapeutic plan are being implemented to enable the student to return to school? _____

Precautions/Restrictions: _____

Is student now hospitalized? ☐ Yes ☐ No If Yes, where? _____ Anticipated Discharge Date _____

Is student contagious? ☐ Yes ☐ No

Is student physically capable of attending classes on any school campus now? ☐ Yes ☐ No

If Yes, please note restrictions, if any (ie: use of stairs, bathroom needs, Physical Education assignment, length of day, etc.): _____

Does student need a specially adapted school campus to meet his/her physical needs? ☐ Yes ☐ No If Yes, explain: _____

➔ Estimate date student may return to a school campus: _____ ☐ Part time ☐ Full time

Physician's Signature _____ M.D. Date _____

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

FAX: (____) _____

Address _____ City _____ Zip _____

SEE INFORMATION ON BACK