

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 _____

IMPLEMENTATION OF SERVICE

HOSPITAL TEACHING - Hospital Instruction will be provided in a manner consistent with California laws governing home/hospital teaching. Instruction is offered in two (2) basic subject areas unless additional courses are approved by a Carlson administrator.

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 Instructional Program and Hospital School.
- The student will be disenrolled from his/her regular school of attendance (cumulative record carrying school) during the period he/she is receiving hospital instruction. 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.