

REFERRAL FOR HOME/HOSPITAL INSTRUCTION (HHI)

Referral made by (please check): Physician IEP Team

Student Name: _____ Birthdate: ___/___/___

Grade: _____ School: _____ Student ID#: _____

SpEd(Y/N): ___ 504(Y/N): ___ Last Date Attended ___/___/___ Teacher/Counselor: _____

Parent/Guardian: _____ Relationship to student: _____

Student Address: _____ Phone: _____

I understand and agree to the requirements of Home/Hospital instruction and agree to be present for the duration of all instructional services.

Signature of Parent/Guardian: _____ Date: _____

MEDICAL VERIFICATION

*****MUST BE OFFICIAL WITH A STAMP OR EMAILED/FAXED WITH A COVER LETTER*****

Required for referral approval, incomplete referral will be denied

A temporary disability means a physical, mental, or emotional disability incurred while a student is enrolled and after which the student can reasonably be expected to return to the regular educational program.

Diagnosis of Temporary Disability: _____

Please describe the conditions that result in the student being home or hospital bound and the rationale for the student's inability to participate in a regular school program:

Length of time required to be in HHI (**3 week minimum**): _____ Start Date: _____

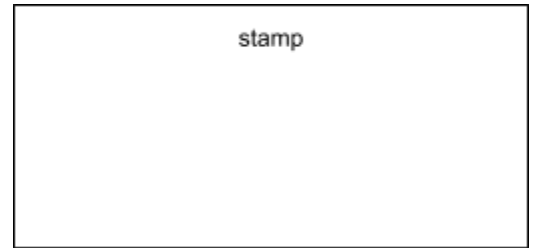
Name of Physician: _____ Phone #: _____

Date: _____

Physician's Signature:

Additional Information Contact: _____

Phone #: _____



STUDENTS REFERRED BY THE IEP TEAM

Please describe conditions and the rationale for the student's inability to participate in a regular school program:

Signature of SPED Coordinator: _____ Date: _____ HHI Length of time: _____

FOR STUDENT SERVICES ONLY

Approved Start Date: ___/___/___ End Date: ___/___/___ Assigned Teacher: _____

Denied, Reason: _____

Admin Signature: _____ Date: _____

DERIVACIÓN PARA INSTRUCCIÓN EN LA CASA O EN EL HOSPITAL

Derivación hecha por (favor de indicar): Médico Equipo de IEP

Estudiante: _____ Fecha de nacimiento: ___/___/___

Grado: _____ Escuela: _____ No. de identificación estudiantil: _____

Educ. Especial(S/N): ___ 504(S/N): ___ Última fecha de asistencia ___/___/___ Maestro/Consejero: _____

Padre/Tutor: _____ Relación del estudiante: _____

Dirección del estudiante: _____ Número. de teléfono: _____

Entiendo y acepto los requisitos de Instrucción en la Casa o el Hospital y aceptó estar presente por la duración de todos los servicios educativos.

Firma del padre/tutor: _____ Fecha: _____

MEDICAL VERIFICATION

*****MUST BE OFFICIAL WITH A STAMP OR EMAILED/FAXED WITH A COVER LETTER*****

Required for referral approval, incomplete referral will be denied

A temporary disability means a physical, mental, or emotional disability incurred while a student is enrolled and after which the student can reasonably be expected to return to the regular educational program.

Diagnosis of Temporary Disability: _____

Please describe the conditions that result in the student being home or hospital bound and the rationale for the student's inability to participate in a regular school program:

Length of time required to be in HHI (3 week minimum): _____ Start Date: _____

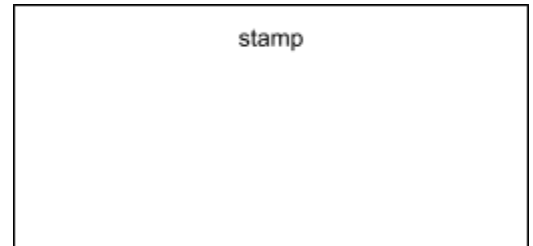
Name of Physician: _____ Phone #: _____

Date: _____

Physician's Signature:

Additional Information Contact: _____

Phone #: _____



STUDENTS REFERRED BY THE IEP TEAM

Please describe conditions and the rationale for the student's inability to participate in a regular school program:

Signature of SPED Coordinator: _____ Date: _____ HHI Length of time: _____

FOR STUDENT SERVICES ONLY

Approved Start Date: ___/___/___ End Date: ___/___/___ Assigned Teacher: _____

Denied, Reason: _____

Admin Signature: _____ Date: _____

Educational Support Services, Student Services

2080 Mission Ave, Oceanside, CA 92058

Phone: 760-966-7837 Fax: 760-439-8095

Email: ruby.barba@oside.us