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 #: _____

stamp

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

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

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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 #: _____

stamp

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HHI Length of time:

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