LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Medical Services Division

REQUEST FOR HOME/HOSPITAL INSTRUCTIONAL PROGRAM

SCHOOL: Please complete information above the first double line and send to the student's physician along with a return envelope addressed to: *School Nurse, Berenece Carlson Home/Hospital School, 10952 Whipple Street, North Hollywood, CA 91602. Phone: (818) 509-8759. FAX: (818) 505-0246.*

STUDENT INFORMATION

Name ______________________ M____ F____ Birthdate ____/____/____ Grade ______

Address ______________________ City ______________ Zip ________

Home Phone ( ) ____________ Work Phone ( ) ____________ Student Language ____________

Parent/Guardian ______________________ Parent/Guardian Language ____________

School of Attendance ______________________ Track ____ Cluster ____ Phone ( ) ____________

PHYSICIAN: Please complete the section below. Sign and return via U.S. mail in the enclosed envelope, or by FAX.

The above-named student, your patient, has requested a Home/Hospital Instructional Program. The California Administrative Code requires that a licensed physician and surgeon file a statement which includes a diagnosis of orthopedic or other physical health impairment to the extent that the student is physically unable to attend classes on any school campus.

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis: ______________________

Summary of Medical Problem: ______________________

____

Precautions/Restrictions: ______________________

____

Is student contagious? Yes ☐ No ☐ Is student now hospitalized? Yes ☐ No ☐

If so, where? ______________________ Expected Discharge Date ____________

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

If yes, please note restrictions, if any (i.e., use of stairs, bathroom needs, Physical Education assignment, length of any, etc.) ______________________

Does student need an adapted school campus to meet his/her needs? Yes ☐ No ☐

Explain if yes: ______________________

☞ Estimate date student may return to a full-time school program: ____________

Physician's Signature ______________________ M. D. Date ____________

Physician's Name (Print) ______________________ M. D. Phone ____________

Physician's Address ______________________ City ____________ Zip ______

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