



San Juan  
Unified School District

# SAN JUAN UNIFIED SCHOOL DISTRICT HOME & HOSPITAL INSTRUCTION

3700 Garfield Ave., Room 18  
Carmichael, CA 95608  
(916) 971-7017 Fax: 971-5733

## PARENT AGREEMENT

Home & Hospital Instruction (HHI) is a limited program available to students who are temporarily ill or injured and require instruction at home for a short period of time. Please check each box after reviewing.

- Students may be referred to the HHI if they are unable to attend school due to a serious injury or illness which will result in school absence for at least three consecutive weeks.
- School site accommodations and/or alternative educational options such as independent study, charter schools, home schooling, school day reduction or other modified instruction should be considered **BEFORE** a referral is made to HHI.
- Home instruction may be made available immediately at the onset of health problems if it appears the absence will exceed three weeks.
- For enrollments exceeding six weeks, you may be required to provide the Home and Hospital Instruction office with an updated Physician or Mental Health Referral form.
- Mental health referrals are limited to a maximum of 60 days on home instruction and require a psychiatrist signature.
- Regardless of physician recommendation, the SJUSD HHI office will determine the appropriateness of placement on an individual basis. Recommendations not meeting California Education Code criteria for HHI will be denied. Should your request to enroll or extend enrollment in HHI be denied, you may appeal the decision in writing.

Home & Hospital Instruction will not commence until the following forms have been received and approved by the program office:

- Physician Referral (completed & signed by M.D.) or Mental Health Referral (completed & signed by Psychiatrist)
- Parent Agreement (completed & signed by parent)
- Authorization for Exchange of Confidential Information (completed & signed by parent)
- For all Special Education referrals - Individualized Education Plan (IEP) designating Home & Hospital Instruction (Addendum)

In order for Home & Hospital Instruction to commence and continue as planned, the parent/guardian of the student designated for home instruction must review and agree to the following requirements. Please check each box after reviewing.

- The student must be ready for instruction at the specified time, with materials, books, and his/her physical needs met.
- The parent, guardian, or another responsible adult 25 years or older, must be present and visible in the home during the instructional period.
- A quiet place must be provided, with a suitable working surface, where the teacher and student can work without interruption.
- It is important to see that your child completes the daily assignments that are required. If you have questions or concerns about your youngster's instruction or homework assignments, please discuss them with the home instructor.
- Notify the home instruction teacher at least 24 hours in advance if your child is unable to receive home instruction on a scheduled day. Make-up session/time is scheduled at the discretion of the teacher.
- Instruction will be offered to students between the hours of 8 a.m. and 3 p.m. (unless otherwise agreed upon by teacher & parent)
- Some classes cannot be taught on home instruction. No schedule is guaranteed. An alternative schedule may be offered.
- If a student is enrolled in HHI during the second semester of their senior year, he/she may not be eligible for senior privileges at their regular high school, such as graduation ceremonies, dances, picnics, trips, etc. Receipt of a diploma must be coordinated with the regular high school counselor.

Student's Name	Date of Birth	School Currently Attending
Mother/Guardian's Name	Best Contact Phone Number	Email Address
Address	City	Zip Code
Father/Guardian's Name	Best Contact Phone Number	Email Address
Address	City	Zip Code

I have read the above statements and understand that these requirements must be met in order for home instruction to commence and continue. Failure to adhere to the above requirements shall result in the termination of home instruction.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Enrollment forms can be mailed or delivered to the HHI office, faxed to 971-5733, or scanned and emailed to [josephine.stewart@sanjuan.edu](mailto:josephine.stewart@sanjuan.edu). Questions about the Home & Hospital Instruction program should be directed to Josephine Stewart, Secretary or Sandra Butorac, Program Manager at 971-7017.



# San Juan Unified School District

## Home and Hospital Instruction

3700 Garfield Ave., Room 18, Carmichael, CA 95608  
 Carmichael, CA 95609-0477  
 Telephone: (916) 971-7017 Fax: (916) 971-5733

### AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL

Student Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**By signing this authorization, I am consenting to the exchange of information between:**

Physician/ Agency:	SJUSD Home & Hospital Instruction
Agency	Agency 3700 Garfield Ave., Room 18
Address	Address Carmichael, CA 95608
City, State, Zip Code	City, State, Zip Code (916) 971-7017 (916) 971-5733
Telephone Number      Fax Number (required)	Telephone Number      Fax Number

**Disclosure of information shall be limited to:**

- |   |  |
|---|--|
| <input type="checkbox"/> Entire record (excludes HIV & Drug/Alcohol information)<br><input type="checkbox"/> School information/Educational records<br><input type="checkbox"/> Psychosocial information<br><input checked="" type="checkbox"/> Treatment plan & progress<br><input checked="" type="checkbox"/> Medical/Health information | <input checked="" type="checkbox"/> Psychological reports<br><input checked="" type="checkbox"/> Psychiatric assessment<br><input type="checkbox"/> Discharge summary<br><input type="checkbox"/> Other: _____ |
|---|--|

**Disclosing this information is for the following purposes:**

- |  |  |
|--|--|
| <input type="checkbox"/> Educational assessment<br><input checked="" type="checkbox"/> Educational planning<br><input type="checkbox"/> Treatment planning | Other: _____<br>(Be specific)<br>_____ |
|--|--|

**Expiration (required)**

This authorization shall remain valid until \_\_\_\_\_  
(must be no longer than a year from date of signature)

**Your Rights**

I understand that I have a right to receive a copy of this authorization. I have the right to refuse to sign this form. I understand that I may revoke or modify this consent at any time by providing written notice. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization.

**Restrictions**

I understand that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

**Approval**

A copy of this authorization is valid as an original.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Relationship to Student*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Student*

\_\_\_\_\_  
*Date*

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**MENTAL HEALTH REFERRAL**

Patient / Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PSYCHIATRIST:** The San Juan Unified School District provides home and hospital instruction for students **unable to attend school for a period of at least three weeks**. The condition must be verified by a **LICENSED PSYCHIATRIST**. If you wish to recommend a patient for Home & Hospital Instruction, please complete the following and return either to the parent or to the address above. **Please complete this form legibly and in its entirety in order to move forward with process without delay.**

Psychiatrist's Statement

Is student capable of attending classes on his/her school campus now, with accommodations to meet their emotional needs? Yes  No

**If yes, please list accommodations:**

\_\_\_\_\_

**If no, please complete the information below:**

DSM IV Diagnosis: \_\_\_\_\_

Summary of Therapeutic Plan: \_\_\_\_\_

\_\_\_\_\_

What medication(s) is/are the student currently prescribed? \_\_\_\_\_

\_\_\_\_\_

Is the student a danger to self or others? Yes  No

Explain: \_\_\_\_\_

\_\_\_\_\_

Why is the student unable to attend school? \_\_\_\_\_

\_\_\_\_\_

What aspects of the treatment plan are being implemented to enable the student to return to school? \_\_\_\_\_

\_\_\_\_\_

Date student may return to school: \_\_\_\_\_ (Referral not to exceed 60 days)  
Psychiatrist's Signature \_\_\_\_\_ M.D. Date \_\_\_\_\_

Psychiatrist's Contact Information/Medical Stamp

Psychiatrist's Name (Print) \_\_\_\_\_ M.D. Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_