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 inwriting.**

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 theteacher.
- ☐ 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. Questions about the Home & Hospital Instruction program should be directed to Josephine Stewart, Secretary or Sandra Butorac, Program Manager at 971-7017.

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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:

- ☐ Entire record (excludes HIV & Drug/Alcohol information)
- ☐ School information/Educational records
- ☐ Psychosocial information
- ☑ Treatment plan & progress
- ☑ Medical/Health information
- ☑ Psychological reports
- ☑ Psychiatric assessment
- ☐ Discharge summary
- ☐ Other:_____

Disclosing this information is for the following purposes:

- ☐ Educational assessment
- ☑ Educational planning
- ☐ Treatment planning

Other:_____
(Be specific)
_____

Expiration (required)

This authorization shall remain validuntil_____
(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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PHYSICIAN REFERRAL

Patient/Student Name_____ Date of Birth _____

PHYSICIAN: 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** because of serious illness or injury. The condition must be verified by a **licensed California physician**. 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 note - do not use this form for mental health referrals. Use Mental Health Referral form. ***Please complete this form legibly and in its entirety in order to move forward with process without delay.***

Physician's Statement

This is to certify that the above named student is under my professional care. He/she will be unable to attend school for a period of at least three weeks or more.

Is student physically capable of attending classes on his/her school campus now, with accommodations to meet their physical or other needs? Yes ☐ No ☐

If yes, please list accommodations:

_____

_____

If no, please complete the information below: Procedure / Surgery Date, if applicable: _____

Diagnosis:_____

_____

Summary of Therapeutic Plan to enable the student to return to school:

_____

_____

Limitations, restrictions, or precautions the teacher should take in teaching this student:

_____

Medicine or treatment may cognitively affect the student in this manner:

_____

Is student's condition contagious? Yes ☐ No ☐

I estimate this student will be homebound until (***Specific date required***):_____

Physician's Signature_____M.D. Date_____

PAs / NPs / Electronic Signatures are not permitted

Physician's Contact Information or Medical Stamp

Physician's Name_____Phone ( ) _____

Address_____City_____Zip _____