 outdoors
SAN JUAN UNIFIED SCHOOL DISTRICT
HOME & HOSPITAL INSTRUCTION
3700 Garfield Ave., Room 18
Carmichael, CA 95608
(916) 971-7017  Fax: 971-5733

PHYSICIAN REFERRAL

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.

Attending 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:

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 __________________

Physician’s Contact Information/Medical Stamp

Name ___________________________ Phone (_________)

Address ___________________________ City ___________________________ Zip ___________
San Juan Unified School District

Home and Hospital Instruction
3700 Garfield Ave., Room 18, Carmichael, CA 95608
P.O. Box 477, Carmichael, CA 95609-0477
Telephone: (916) 971-7017 Fax: (916) 971-5733

Authorization for Exchange of Confidential Information

Student Name: ___________________________ Student ID#: ___________________________ Date of Birth: ___________________________

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

<table>
<thead>
<tr>
<th>Agency/Physician</th>
<th>SJUSD Home &amp; Hospital Instruction</th>
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<tbody>
<tr>
<td>Agency</td>
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<td></td>
<td>3700 Garfield Ave., Room 18</td>
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<td>Address</td>
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<td>Carmichael, CA 95608</td>
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<td>City, State, Zip Code</td>
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<tr>
<td></td>
<td>(916) 971-7017</td>
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<tr>
<td>Telephone Number</td>
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<tr>
<td>Fax Number</td>
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Disclosure of information shall be limited to:

- [ ] Entire record (excludes HIV & Drug/Alcohol information)
- [ ] School information/Educational records
- [ ] Psychological reports
- [ ] Psychiatric assessment
- [ ] Treatment plan & progress
- [ ] Other: ___________________________
- [x] Medical/Health information
- [ ] Discharge summary
- [ ] Other: ___________________________

Disclosing this information is for the following purposes:

- [ ] Educational assessment
- [ ] Educational planning
- [ ] Treatment planning
- [ ] Other: ___________________________

Expiration
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: ___________________________

Student 8/1/17 (3 of 3)