Student Support Services
Health Services
HHI (HOME HOSPITAL INSTRUCTION)
975 North D Street
Stockton, CA 95205
(209) 933-7060

APPLICATION FOR MEDICAL REFERRAL

-CHECKLIST –

Please complete the attached forms and include the following:

- ☐ Medical Referral Application Completed SUSD Authorization for Release of Health Information
- ☐ Copy of Treatment Plan
- ☐ Other relevant information, as available; i.e., assessments, evaluation, hospital discharge documents, etc.
- ☐ Student's Transcript & Class Schedule (high school)
- ☐ Student Profile/Information page
- ☐ IEP/504 Plan

APPLICATION MUST BE FILLED OUT COMPLETELY BEFORE IT CAN BE PROCESSED

Applications are accepted via in-person or email.

EMAIL THIS FORM TO:
Jserena@stocktonusd.net
Attn: HHI (Home Hospital Instruction)

Stockton Unified School District
Since 1852

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MEDICAL REFERRAL APPLICATION

(ONLY COMPLETED APPLICATIONS WILL BE PROCESSED)

This request is valid for the current school year only _____

Initial Request ☐ Extension Request ☐ (if extension, initial request date:_____)

Student's Information

Last name_____ First name_____ M ☐ F ☐

D.O.B._____/_____/_____ Grade_____ Student ID_____ Counselor/ Teacher _____

School_____

Parent/Guardian _____ Phone Number _____

Address _____ City _____ Zip _____

Does student have a current IEP? Yes No Eligibility _____

504 Plan? Yes No Condition related to the 504 Plan _____

The following modified programs or other educational options have been tried (please check all that apply):

☐Enrolled in a shortened school day.

☐ Enrolled in an Independent Study Program allowing the student to complete course work independently, at home, and review work once a week with a teacher for a grade.

☐ Developed and implemented a Section 504 Plan to accommodate student needs through program modifications (ie: modify a class schedule, adjust placement of a student, increase/decrease opportunity for movement, etc.)

☐Identified as eligible for special education services and an Individualized Education Program (IEP)

HHI (HOME & HOSPITAL INSTRUCTION)

Consistent with California laws, five (5) hours per week of instruction will be provided to your child. A responsible adult, 18 years of age or older, must be present when the teacher is in the home.

By signing, Parent/Legal Guardian and/or Student Authorizes the Doctor to Release Information to Stockton Unified School District to review eligibility for Home Hospital Instruction.

_____ _____

Parent/Guardian Signature **Date**

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This request is valid for the current school year only _____

Student Name _____ D.O.B. _____

Physician's Certification

PHYSICIAN: A request for **temporary** Home & Hospital Instruction has been made for the above-named student. California Education Code §44873 requires that a licensed California physician file a statement that includes a medical diagnosis to the extent that the student is unable to attend classes on any school campus. There are no other services provided by the school, i.e. speech therapy, OT, PT, etc. **Chronic conditions** may not qualify.

Is the student physically capable of attending classes on his/her school campus with accommodations to meet their physical or other needs? YES NO

If yes, please list accommodations: _____

_____

If no, please complete the information below. Diagnosis/Condition: _____

_____

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

_____

Limitations, restrictions or precaution the school should be aware of: _____

_____

Is the student's condition contagious? YES ☐ NO ☐

Date student can return to regular school (required): _____

If the return date is unknown, will the return date be a minimum of 4 weeks from the date you sign this form? YES ☐ NO ☐

Physician's Signature _____ Date _____

Physician's Name (Print) _____ Phone _____

Address _____ City _____ Zip _____

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Authorization for Release of Health Information

1. **STUDENT/ PATIENT INFORMATION**:

Name: _____ Date of Birth: _____

LAST FIRST MI

2. **INFORMATION TO BE RELEASED FROM**:

____ _____ School District
____ California Children's Services (CCS)
____ Medical Therapy Unit
____ Valley Mountain Regional Center
____ St. Joseph's Medical Center
____ UCSF Medical Center
____ Children's Hospital Oakland
____ San Joaquin General Hospital
____ Dameron Hospital
____ Kaiser Permanente
____ Public Health Services
____ San Joaquin County Behavioral Health
____Physician/Clinic/Other:
_____

3. **INFORMATION TO BE RELEASED TO AND USED BY STOCKTON UNIFIED SCHOOL DISTRICT:**

School/Department _____ Contact Person _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

4. **PURPOSE OF THE REQUESTED INFORMATION**:

____ Authorization forwarded at the request of Parent/Legal Guardian

____ Assist in determining most appropriate school education program / learning accommodations

____ Other: _____

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5. **TYPE / DESCRIPTION OF INFORMATION REQUESTED**:

____ Immunization Record ____ Operative Reports ____ Ambulatory Clinic Summary
____ Physician Orders ____ Lab/X-ray Results ____ Appointment Dates/Times
____ History and Physical ____ Discharge Summary ____ Mental Health Records

6. **AUTHORIZING RELEASE OF INFORMATION**:

- By signing below, I understand that the information released may include information regarding treatment, hospitalization, or outpatient care, including psychological/psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests unless otherwise excluded here: ☐
- I also understand that the school district is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological, and health records are exchanged among California public schools.
- I have read and understood the "Authorization Restrictions and Rights" on the backside of this form which includes my right to refuse to sign this authorization, to revoke this authorization, and to receive a copy of this authorization.
- If you authorize the disclosure of information to a person or entity that is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by state or federal law.
- DURATION: Unless revoked, this authorization will expire 1 year from date of signature, unless otherwise specified here:_____ to _____.

_____

Signature of Parent / Legal Guardian **Relationship** **Date**

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Authorization Restrictions and Rights

- Signing this authorization is voluntary. You can refuse to sign this authorization. Refusing to sign this authorization will not affect Stockton Unified School District's commitment to providing a quality education for your child; however, refusing to sign may inhibit the school's ability to implement an optimal plan of education, learning accommodations and/or health care plan for your child.
- This authorization may be revoked at any time. To revoke this authorization, you must provide the organization or individual listed in Section B of this form, with a written request to revoke the authorization. Any information disclosed before your written revocation is received may be used as previously permitted.
- You have the right to receive a copy of your "Authorization for Release of Health Information." If you request it, you will receive a copy of this authorization after you sign it.
- Stockton Unified School District is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological and health records are exchanged among California Public Schools. No further disclosure of this information, by Stockton Unified School District, should be done without specific, written and informed release by parent/legal guardian.
- You may inspect or copy the information to be disclosed, as provided in CFR 164.524.

This document was translated to parent/legal guardian into _____.

This document was read to the patient verbatim and questions, if any, were answered prior to signature.

Translated by: _____ Date: _____