HOME & HOSPITAL APPLICATION - PHYSICIAN'S REPORT MADERA UNIFIED SCHOOL DISTRICT
1837 Howard Road. Madera CA 93637
Phone. 559-416-5800 ext. 13121 Fax. 559- 661-2031
Caitlin Pendley, Health Services Coordinator
Samantha Gonzalez, Office Assistant
Email Application: homehospital@maderausd.org

SECTION III: Physician Certification

Education Code § 48206.3(b)(2) defines "temporary disability" as follows: …A physical, mental or emotional disability incurred while the pupil is enrolled in regular day classes or an alternative education program, and after which the pupil can reasonably be expected to return to regular day classes or the alternative education program by the district in which the pupil is deemed to reside.

STUDENT'S NAME_____ **ID#:**_____

Birth date: _____/_____/_____ **Age:** _____ **Grade**_____

PHYSICIANS REPORT (Items 1- 12 must be completed)

Education Code § 48206.3:
"A student with a temporary disability which make school attendance impossible or inadvisable shall receive individual instruction in the student's home or in a hospital…"

1. In order to provide Home/Hospital instruction, a statement from the physician is required. Please provide all detailed information concerning the illness or disability, which prevents the child from attending school daily (Additional pages may be attached if necessary).

_____

2. Recommended Home Hospital START DATE_____ **& END DATE:**_____**(not to exceed 8 weeks)**

3. Does the student have a contagious, infectious, or communicable disease? Yes _____ No_____

4. If pregnant, approximate delivery date _____
5. Additional information needed from the physician for behavior health issues. _____

_____

6. Date of next appointment with student:_____

7. Physician Signature

_____

8. Date 9. Print Physician Name 10. Address 11. Phone 12. Fax HEALTH SERVICES USE ONLY

School making the request: _____ **Date** _____

Approved: Yes_____ **Date of enrollment:** _____ **Teacher Assigned:** _____ **Extension of services:**

Extended to: _____ **No** ____ **Reason for Denial:** _____ **Contact parent: E-mail** _____ **Phone** _____

Date of contact: _____

Contact counselor E-mail_____ **Phone**_____ **Date of contact:** _____

Special Services: 504_____ **IEP**_____ **Case Carrier** _____ **Meeting Date**_____

Approved by: _____ **Coordinator of Health Services Date**

HOME & HOSPITAL APPLICATION - PARENT/GUARDIAN SECTION
MADERA UNIFIED SCHOOL DISTRICT
1837 Howard Road. Madera CA 93637
Phone. 559-416-5800 ext. 13121 Fax. 559- 661-2031
Caitlin Pendley, Health Services Coordinator
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SECTION I: PARENT/GUARDIAN

_____

Student ID # Current School Counselor Name Grade

_____ _____/_____/_____ _____

Student Name Birth Date MM/DD/YEAR Age

_____

_ Student Address Student Cell Number

_____

_ Parent/Guardian Names

_____

Home Phone Cell Phone Work Phone

_____

Parent/Guardian Signature Date

I authorize a physician or other designated health center staff to provide the following information In accordance with all federal and state laws:

□ Yes □ No **Medical Services:** comprehensive physical exams, management of acute and chronic illness, sport, college, and employment physicals, immunizations, first aid, vision and hearing screening, lab tests (anemia, urine), and referrals to higher level care as appropriate

□ Yes □ No **Counseling/Therapy Services:** crisis management, depression, anxiety, behavioral modifications, solution focus therapy, relationship and family issues, stress, low self-esteem, body image issues, eating disorders, and other behavioral health issues**.**
Additional paperwork required for approval of application.

I consent to the exchange of my child's medical information between Madera Unified School District (MUSD) and _____ for the purposes of delivering the above-authorized services. This exchange of medical information shall be bi-directional between MUSD and _____. I understand the student medical records will be like confidential medical records separate from school records, but may be shared with other health care providers for the purposes of my child's care and treatment. I understand that I may cancel this authorization/consent in writing. Otherwise, it will apply for the duration of my child's enrollment in school.

Print Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Student Signature: _____ Date: _____

Home Hospital Coordinator Signature: _____ Date: _____