A COPY OF IMMUNIZATION RECORDS ARE REQUIRED WITH THIS REFERRAL

LOS ANGELES UNIFIED SCHOOL DISTRICT

Carlson Home Hospital School

10952 Whipple St., No. Hollywood, CA 91602
Phone: (818) 509-8759 FAX: (818) 505-0246

HOME MEDICAL REFERRAL

Student Information

Last Name_____ **First Name**_____ ☐ **M** ☐ **F**

DOB_____/_____/_____ **Gr.** _____ **Student Language**_____ **Parent/Guardian Language** _____

Address _____ **City**_____ **Zip**_____

Home Phone ( ) _____ **Cell Phone** ( ) _____ **Work Phone** ( ) _____

Parent/Guardian _____ **Parent Email Address** _____

Do you have Internet Access? ☐ **Yes** ☐ **No** **Student Email Address** (Gr. 6-12)_____

School of Attendance _____ **Phone** ( ) _____ **Last date of attendance** _____

School of Residence _____

Does student have a current IEP? ☐ **Yes** ☐ **No** **Eligibility**_____ **504 Plan?** ☐ **Yes** ☐ **No**

IMPLEMENTATION OF SERVICE

Carlson Home Online Academy (CHOA) Home Instruction will provide students in grades 6/7–12 on the General Ed Curriculum up to 15-20 hours of instruction per week in up to four or five (4-5) subject areas. Students eligible for CHOA may be provided face-to-face home instruction for five (5) hours of instruction in 2 basic subject areas per week on a case-by-case basis in lieu of participating in CHOA.

Face-to-Face Home Instruction will provide students in grades TK–5/6 on the General Ed Curriculum or in grades TK–12 on the Alternate Curriculum five (5) hours of instruction per week. Instruction is offered in two (2) basic subject areas. English Learners and Standard English Learners will be provided additional instruction in ELD/MELD. A responsible adult (18 years of age or older) identified in writing by educational rights carrier must be present when the teacher is in the home.

By signing this authorization for service, the parent/guardian is agreeing to the following:

- ► If the student is eligible, educational services will be temporarily provided by the Carlson Home Hospital School.
- ► The student will be temporarily disenrolled from his/her regular school of attendance (cumulative record carrying school) during the period he/she is receiving Carlson services. Grades and marks will be reported to the cumulative record carrying school.
- ► Educational information will be accessed and used to plan and provide an appropriate educational program for the student.
- ► Permission to provide services or access school records may be revoked via written parent/guardian request at any time.
- ► Carlson provides home instruction between the hours of 8:00 a.m. and 7:00 p.m. No specific schedule nor teacher can be guaranteed.

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION AND TEMPORARILY TRANSFER EDUCATIONAL DUTIES:

Parent Signature_____ **Date** _____

California Licensed Health Care Provider must complete page 2 to authorize service

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HOME MEDICAL REFERRAL

Student Name _____ **D.O.B** _____

PHYSICIAN, DOCTOR OF OSTEOPATH, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER: A request for temporary Home Instruction has been made for the above-named student. This referral form (page 2 of 2) must be completed by A California licensed MD, DO, PA, or NP in order to be considered, and must include a diagnosis and the length of time the student is anticipated to be confined. **Chronic conditions** may not qualify.
DO NOT USE THIS FORM FOR PSYCHIATRIC CONDITIONS. (USE ATTACHMENT C).

Attending Health Care Provider's Statement

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, student does NOT qualify for home instruction. List accommodations to be used at the student's current school campus: _____

_____

If no, complete the information below:

Diagnosis: _____

_____

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

_____

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

_____

Is student's condition contagious? ☐ **Yes** ☐ **No**

This section to be completed by a licensed physician, osteopath, physician's assistant, or nurse practitioner: **Estimated date student may return to school (*Specific* date required)** RQD: Estimated Date of Return ___ / ___ / _____		
Signature	**MD, DO, PA, NP (circle one)**	**Date**
Print Name		**Phone**
Print Title		**Fax**
Print name of supervising physician		
Address	**City**	**Zip**