



**Guadalupe Union School District
Application for Home/Hospital Instruction**

1. **Sections A and B should be completed and signed before returning to school site.**
2. The School Principal, Assistant Principal or School Nurse will complete and sign Section C.
3. The application is then submitted to Pupil Services with this fully executed application, home teaching is offered to students who are unable to attend school for a period of at least 2 weeks.

A. TO BE COMPLETED BY PARENT/GUARDIAN (Please Print)

1. It is your responsibility:
 - a. To make sure that you or another responsible adult is home during instruction.
 - b. To provide a quiet place that is conducive to good learning.
2. After completing Section A, have **Section B** of this form **completed by your physician.**
3. Parents must either return this form to the school office or have physician FAX it to the school.
4. I authorize the exchange of information, including psychological and/or medical information regarding my son/daughter. Initial Here _____

Student's Name: _____

Birthdate: _____ School: _____

Grade: _____ Date of Last Attendance: _____

Parent/Guardian: _____ Home Phone: _____

Address: _____ Message Phone: _____

Parent/Guardian

Signature: _____ Date: _____

B. TO BE COMPLETED BY MEDICAL PROFESSIONAL

1. It is school policy to provide home instruction for students who will be absent for a period of at least 2 weeks for medical reasons.
2. If a student will be absent for more than 6 weeks, a follow-up exam and written report will be required from you at that time.
3. Medical Diagnosis:

Student confined to bed/home until: _____

Follow-up appointment date: _____

Comments: _____

_____ Does student have any physical limitations that will affect his/her ability to participate in Physical Education activities? Yes

No If Yes, explain: _____

Physician's Name: _____

Phone: _____

Physician's Signature: _____

Date: _____

Please fax this form to the student's school at: _____

C. TO BE COMPLETED BY PRINCIPAL or ASSISTANT PRINCIPAL

School Site: _____

Teacher: _____

Please attach student's schedule. Identify which class(es) student requires Home Hospital instruction and any classes he/she will attend on school site.

Student receiving special education services –

Yes No Special Education Teacher: _____

Signature: _____ Title: _____

Date: _____

For Office Use Only

Instructor Assigned: _____

Date: _____ Notes: _____

Signature Pupil Services Director : _____ Approval Date: _____

Initial _____ Start Date: _____

Home Hospital Instruction Dates/checklist

Superintendent or Designee approval of HH w/in 5 days of receiving parent request
HH commences within 5 days of Eligibility determination.

____ District receipt of parent notification of absence that will be at least 2 weeks long

____ Physician's note valid _____ through _____

____ Aeries; demographics face page attached

____ Verification of address/contact info w/Office Manager and Home Room Teacher

____ Confirmed Home Room Teacher has declined extra assignment

____ Position posted for Home Hospital Instructor by Human Resources

____ Email request for homework to Home Room Teacher by Principal/Office Manager

____ Notification to School Administrator, Office Manager, Home Room Teacher, School Nurse and Pupil Services Director when position is filled & Home Instruction begins

____ Classwork for Home Hospital Teacher provided by Home Room Teacher

____ Home Hospital extension by physician is valid _____ through _____