



Home / Specialized Programs / Educational Options / Home & Hospital Instruction

Home and Hospital Instruction Program Summary

Provides information on program purpose, services, outcomes, students served, and results for Home and Hospital Instruction.

Purpose

The purpose of home and hospital instruction is to provide instruction to a student with a temporary disability in the student's home or in a hospital or other residential health facility, excluding state hospitals.

A temporary disability is defined as a physical, mental or emotional disability incurred while a student is enrolled in regular day classes or an alternative education program, and after which the student can reasonably be expected to return to regular day classes or the alternative education program without special intervention.

A temporary disability does not include a disability for which a student is identified as an individual with exceptional needs pursuant to California *Education Code (EC)* Section 56026.

Program/Services

School districts shall notify parents at the beginning of a school term of the availability of individualized instruction for pupils with a temporary disability. (*EC* sections 48206.3[d] and 48980)

A student with a temporary disability who is in a hospital or other residential health facility, excluding a state hospital, located outside of the school district in which the student's parent or guardian resides, shall be deemed to have complied with the residency requirements for school attendance in the school district in which the hospital is located. (*EC* Section 48207)

It is the primary responsibility of the parent or guardian of a student with a temporary disability to notify the school district in which the student is deemed to reside of the student's presence in a qualifying hospital. Within five working days following notification from the parent or guardian, the school district shall determine whether the student will be able to receive individualized instruction, and, if the determination is positive, when the individualized instruction may begin. Individualized instruction shall start no later than five working days after the positive determination has been made. (*EC* Section 48208)

EC Section 48206.3 specifies that for attendance accounting each clock hour of individualized instruction counts as one day of attendance. No student shall be credited with more than five days of attendance per calendar week or credited with more than the total number of calendar days that regular classes are offered by the district in any fiscal year.

Outcomes

The primary outcome of Home and Hospital Instruction is to maintain a student at the student's former level of performance while recovering from the temporary disability so as not to jeopardize the student's future performance upon returning to a regular day class or alternative education program.

Funding

General Fund apportionment is based on average daily attendance.

Students Served

Home and Hospital Instruction serves students with a temporary disability (*EC* Section 48206.3[b][2]) that makes attendance in the regular day classes or alternative education program in which the student is enrolled impossible or inadvisable, excluding students with "exceptional needs" (*EC* Section 56026).

Results

Students are prepared to return to their regular day class or an alternative education program at their former level of performance.

Questions: Jacie Ragland | jragland@cde.ca.gov | 916-323-2568

Last Reviewed: Friday, February 19, 2016

Victor Valley Union High School District Home and Hospital Instruction Application

Student Name:		Age:	DOB:	Sex:
School of Attendance:	Grade:	Student #	RSP	SDC Reg Ed Other
Parent Guardian:				
Home Address:				
State:	Zip Code:	Home Phone:	Work Phone:	

Name of Physician:		
Address and Phone Number:		
Specific Reason for Request:		
Is the Student in a CONTAGIOUS STATE:	YES NO (Please Circle)	Copy of protocol attached?
Expected Absence Start Date:	Expected End Date	If pregnant, due date:

Completed By:	Date:
Comments, Special Considerations, or Restrictions:	

Consent for Release of Information

I, the undersigned, hereby authorize (the) _____ to release any or all medical and/or psychological information regarding the above named student to Victor Valley Union High School District for inclusion in their records which are to be used for offering services to said person.

Signature of Parent/Guardian: _____ Date: _____

Recommendation of _____ Date: _____
Approval -- District Nurse: _____ VVUHSD District Nurse

Approved _____ Date: _____
Denied _____ Margaret Akinnusi - Director, Special Education/Student Support Services

Home Instruction Teacher Assigned: _____	Start Date: _____
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Victor Valley Union High School District

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Physician's Recommendation for Home Hospital Instruction

To: Physician

Alternative education programs are provided for students who are ill with non-contagious illnesses, who are injured or otherwise incapacitated, and who are therefore unable to attend school in a regular classroom setting. **Please note that the State of California allows only 5 hours of service each week, thus this program should be considered temporary and a last resort.** This service will be continued as long as the pupil is under continued medical care and is deemed unable to attend school. An adult eighteen years or older must be present in the home during Home and Hospital Instruction services.

Home and Hospital Instructions Eligibility – Student enrolled in Home and Hospital instruction are those students deemed to be “home bound” due to medical and/or psychiatric conditions and therefore must receive all instruction at home. These students are deemed physically or mentally unable to participate in our Independent Study program alternative, which includes a minimum attendance requirement of one two hours per week in a classroom designated for teacher contact and support.

TO BE COMPLETED BY PHYSICIAN (M.D. OR D.O. ONLY)

Patient's Name: _____ (Please print clearly)

Recommendation: (Initial appropriate choice using attached state guidelines)

Home and Hospital Instruction _____

Independent Study or school attendance w/ accommodations _____

Physician's Signature: _____ Date: _____

Address: _____

Phone: _____ License #: _____

****IF HOME AND HOSPITAL IS RECOMMENDED****

Diagnosis necessitating Home and Hospital Instruction: _____

Date Home and Hospital Instruction is to **BEGIN:** _____ **END:** _____

I, _____, certify that the above named student is unable to function on a regular school campus, even on a modified basis, because of his/her medically disabling condition. I am aware that the Home and Hospital Instruction program is available only to students who are home or hospital bound and I am recommending, on a temporary basis, Home and Hospital instruction as the **ONLY** appropriate method of instruction.

****Please note: This physician's recommendation must be renewed for each school semester****