TRACY UNIFIED SCHOOL DISTRICT
OFFICE OF SPECIAL EDUCATION
1875 W. LOWELL AVE, TRACY, CA 95376
(209) 830-3270 (Office) (209) 830-3274 (Fax)

MEDICAL REFERRAL FOR HOME HOSPITAL INSTRUCTION

STUDENT INFORMATION

To be completed by parent/legal guardian and then given to student's physician

Name _____ M ___ F___ Date of Birth _____

Address _____ City _____ State _____ Zip _____

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

School _____ Track _____ Grade _____ Teacher/Counselor _____

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RELEASE MEDICAL AND ACADEMIC INFORMATION

Parent Signature _____ Date _____

Parent Name Printed _____

ATTENDING PHYSICIAN'S STATEMENT

To be completed by student's physician and returned to TUSD

A request for Home Hospital Instruction has been made for the above named student. Temporarily disabled pupils are entitled to instruction in their homes or hospitals. For medical authorization of Home Hospital Instruction, per California Education Code 44873, a licensed California physician must provide documentation that states the diagnosed condition, certifies that the severity of the condition prevents the pupil from attending classes, and includes a projected calendar date for the pupil's return to school.

If Home Hospital Instruction is being medically authorized at this time, please complete the remainder of this form, sign below, and return this form to Tracy Unified School District, attn: Sean Brown, Director of Special Education, 1875 W. Lowell Ave, Tracy, CA 95376, or fax to 209-830-3274. Any questions, please contact the Special Education Department at 209-830-3270.

Diagnosis and/or Summary of Medical Problem/ Therapeutic Plan_____

_____

Does severity of condition prevent student from attending school? Yes _____ No _____

Date student is to begin Home Hospital Instruction _____

Date student was last seen by physician _____ Is student contagious? _____ Yes _____ No

Is student now hospitalized? ____ Yes ____ No If so, where?_____ Anticipated Discharge Date _____

If hospitalized, can student complete assignments? _____ Restrictions if any _____

Estimated Calendar Date Student may return to School _____ Precautions/ Restrictions_____

_____

Physician's Signature _____ Date _____

Physicians' Name (Print) _____

Name of Medical Group or Hospital (if applicable) _____

Address _____ City _____

State _____ Zip _____ Phone number _____