REQUEST FOR
HOME/HOSPITAL (H/H) SERVICES

COMPLETED BY PARENT/GUARDIAN

SCHOOL NAME	STUDENT GRADE LEVEL
STUDENT NAME (Last, First, Middle)	GENDER ☐ MALE ☐ FEMALE ☐ NON-BINARY
CONTACT PERSON	TELEPHONE NUMBER

SECTION 1 – COMPLETED BY QUALIFIED MEDICAL PRACTICIONER

DIAGNOSIS:

☐ DISEASE/INJURY/SURGERY (PRIMARY DIAGNOSIS):

_____

_____

_____

☐ DRUG/ALCOHOL TREATMENT

☐ PREGNANCY

☐ OTHER (DESCRIBE):

_____

_____

_____

I certify that this student is unable to attend public school for _____ weeks.
(weeks start as of date signed by qualified practitioner – not to exceed 18 weeks per school year.)

TYPE/PRINT NAME OF QUALIFIED PRACTITIONER	BUSINESS ADDRESS:	
SIGNATURE	DATE	CONTACT NUMBER:

SECTION 2 – SCHOOL DISTRICT USE ONLY

Does the student have an _____ IEP or _____ 504?	CASE MANAGER:			
CHECK ONE: ☐ Original Request ☐ Extension	Beginning date of instructional time or extension:	MO	DAY	YEAR
NOTE: Beginning date on extension request must consecutively follow ending date of original request.				
EXECUTIVE DIRECTOR OF SPECIAL EDUCATION AUTHORIZATION	DATE	Approved ☐	Not Approved ☐	

COUNT DAY

(1) Count Day: _____	(2) Count Day: _____	Returned In-Person Date: _____

LAKEWOOD SCHOOL DISTRICT

Authorization for the Release of Records/Information

Student _____ Birthdate _____

School _____ Grade _____

PURPOSE OF AUTHORIZATION FOR RELEASE OF RECORDS: As a parent or guardian you have the right to give permission or not give permission for the exchange of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Federal Family Education Rights and Privacy Act (for example, transfer of records from one school district to another).

I herby authorize the mutual exchange of confidential information and the release of records among and between the Lakewood School District Public Schools and the person(s) or agency listed below:

To/From (Agency Name or Person)

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone/Fax Number _____

To/From (District employee/title/school/department)

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone/Fax Number _____

Check all records types to be released:

☐ Health/Medical Records ☐ Psychological and Counseling Records ☐ Special Education Records ☐ Transcripts

☐ Other (Specify) _____

The reason for disclosing the record(s) is: _____

I understand that the information obtained by the Lakewood School District will be treated in a confidential manner under the provisions of the Family Education Right and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the District is protected under FERPA privacy standards and not the Health Insurance Portability Act (HIPAA).

Note: For the release of medical records, the authorization will automatically expire 90 days from the date of signing.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/Guardian Signature_____ Date _____

Street Address _____ City, State, Zip _____