PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER • HEALTH PROGRAMS

Our Children. Learning Today. Leading Tomorrow.

MEDICAL REFERRAL FOR HOME HOSPITAL INSTRUCTION

School: Please complete the Student Information: **Aeries Student ID#:**_____

Name:	M ☐ F ☐	DOB / /	Grade:	School:
Address:		City:		Zip:
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )	
Parent/Guardian:				IEP Yes ☐ No ☐
Date of Current IEP:	Eligibility:	Next Review Date:		

This section to be completed by Parent/ Legal Guardian

PARENT/GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL & ACADEMIC INFORMATION relevant to current treatment plan and planning for safe school environment to Pasadena Unified School District:

Parent Signature: _____ Date:_____

This section to be completed by student's attending Healthcare Provider

Summary description of Diagnosis/Medical Problem, Treatment Plan, and Temporary Disability making school attendance impossible or inadvisable:_____

_____

_____

_____

Is student now hospitalized? Yes ☐ No ☐ If yes, where?_____

Anticipated Discharge Date:_____

Is student contagious?.....Yes ☐ No ☐

Is student physically capable of attending classes on any school campus now? ..... Yes ☐ No ☐

➡ **Effective Date** _____ **AND Estimated date of student resuming attendance on the school campus**_____

Attending Physician Signature:_____ Date:_____

Provider/Agency Name:_____ Phone: (___)_____

Address:_____ Fax: (___)_____

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