



ENTERPRISE ELEMENTARY SCHOOL DISTRICT

1155 Mistletoe Lane, Redding, CA 96002 • Phone: (530) 224-4100 • FAX: (530) 224-4101 • www.eesd.net

Empowering every child, every day, to create a better world

HOME MEDICAL REQUEST

Student Information

Last Name _____ First Name _____ M ☐ F ☐

Date of Birth _____ Gr. _____ Student Language _____ Parent/Guardian Language _____

Address _____ City _____ Zip _____

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

Parent/Guardian _____ Parent Email Address _____

Do you have Internet Access? Yes ☐ No ☐ School of Attendance _____

Phone () _____ Last date of attendance _____

Does student have a current IEP? Yes ☐ No ☐ 504 Plan? Yes ☐ No ☐

IMPLEMENTATION OF SERVICE

A Home and Hospital Teacher will provide instruction to students in grades TK–12. One (1) hour of individual instruction is equal to 1 day of attendance; no more than 5 per week. (per EC 48206-3) Instruction is offered in two (2) basic subject areas. A responsible adult (18 years of age or older) must be present when the teacher is in the home.

In person ☐ Virtual ☐ Combination ☐

By signing this authorization for service, the parent/guardian is agreeing to the following:

- ▶ Educational information will be accessed and used to plan and provide an appropriate educational program for the student.
- ▶ Permission to provide services or access school records may be revoked via written parent/guardian request at any time.

PARENT/LEGAL GUARDIAN AUTHORIZATION TO PARTICIPATE IN HOME AND HOSPITAL INSTRUCTION.

Parent Signature _____ Date _____



ENTERPRISE ELEMENTARY SCHOOL DISTRICT

1155 Mistletoe Lane, Redding, CA 96002 • Phone: (530) 224-4100 • FAX: (530) 224-4101 • www.eesd.net

Empowering every child, every day, to create a better world

HOME MEDICAL REQUEST

Student Name _____ Date of Birth _____

PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER: A request for temporary Home Instruction has been made for the above-named student. This request for (page 2 of 2) must be completed by a California licensed MD, DO, PA, or NP in order to be considered, and must include a diagnosis and the length of time the student is anticipated to be confined. Chronic conditions may not qualify. DO NOT USE THIS FORM FOR PSYCHIATRIC CONDITIONS.

Attending Health Care Provider's Statement

Is student physically capable of attending classes on his/her school campus now, with accommodations to meet their physical or other needs? ☐ Yes ☐ No

If yes, student does NOT qualify for home instruction. List accommodations to be used at the student's current school campus: _____

If no, complete the information below:

Diagnosis: _____

Summary of Therapeutic Plan to enable the student to return to school: _____

Limitations, restrictions, or precautions the teacher should take in teaching the student: _____

Is student's condition contagious? ☐ Yes ☐ No

This section to be completed by a licensed physician, osteopath, physician's assistant, or nurse practitioner:

Estimated date student may return to school (Specific date required) RQD: Estimated Date of Return ____/____/____

Signature		MD, DO, PA, NP (select one)	Date
Print Name		Phone	
Print Title		Fax	
Print name of supervising physician			
Address	City	Zip	

TO BE COMPLETED BY ADMINISTRATOR

REQUEST FOR HOME/HOSPITAL TEACHING IS APPROVED.

ADMINISTRATOR SIGNATURE _____

DATE _____

TEACHER ASSIGNED _____

START DATE _____

ESTIMATED END DATE _____

COMMENTS: