Attachment C

Panama-Buena Vista Union School District
Health, Safety and Wellness
4200 Ashe Rd, Bakersfield, CA 93313
(661) 831-8331 ext 6286 FAX: (661) 832-8002

Medical Referral for Home & Hospital Instruction/ Homebound Instruction

DO NOT USE THIS FORM FOR MENTAL HEALTH CONDITIONS. (USE ATTACHMENT D)

Student Name _____ **Date of Birth** _____

PHYSICIAN: A request for temporary Home & Hospital Instruction/Homebound Instruction has been made for the above-named student. Panama-Buena Vista Union School District (P-BVUSD) procedures require that a **licensed California physician or surgeon,** currently treating the student for this condition, file a statement, which includes a medical diagnosis, and the extent that the student is unable to attend classes on any school campus**. Chronic conditions** (i.e., asthma, diabetes, or epilepsy) may not qualify for Home & Hospital Instruction (HHI). Home & Hospital Instruction is not authorized by the doctor, but by the Panama-Buena Vista Union School District. Home & Hospital Instruction is determined by the IEP team. The doctor's role is to provide pertinent medical information to PBVUSD staff so a valid placement may be considered.

Treating Physician Statement:

Is the student physically capable of attending classes on his/her school campus, at this time, with accommodations to meet their physical or other needs? □ **Yes** □ **No**

If yes, please list suggested accommodations: _____

_____

Would the patient's condition prevent/prohibit participation in an alternative, independent study program, meeting individually with a teacher at a school site? □ **Yes** □ **No** (□ 1-2 hrs/wk □ 2-3 hrs/wk □ 3-4 hrs/wk)

Is the patient able to leave the home for reasons other than medical appointments? □ **Yes** □ **No**

Is student's condition contagious? □ **Yes** □ **No**

Diagnosis (with ICD code):_____

_____

_____

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

_____

_____

Limitations, restrictions, or precautions school staff should take when interacting with this student:

I estimate this student will be homebound until (Specific date required): _____
(Not to exceed 90 days from date of request)*

(*Patients with cancer: Requests submitted with physician-signed documentation of treatment schedule may be considered for date beyond 90 days.)

I am managing the student's care for this condition. □ Yes □ No

Physician's Signature _____, M.D. Date _____

Physician's Name (Print) _____ M.D. License # _____

Phone:_____ Fax:_____ Email: _____

Address_____ City_____ Zip _____