Attachment D

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

Mental Health Documentation for Home & Hospital Instruction/ Homebound Instruction

DO NOT USE THIS FORM FOR PHYSICAL HEALTH/ MEDICAL DOCUMENTATION (USE ATTACHMENT C)

Student Name _____ **Date of Birth** _____

Clinical Psychologist: A request for Home & Hospital Instruction/Homebound Instruction has been made for the above-named student. The California Education Code §44873 requires that a licensed California physician or surgeon file a statement which includes a medical diagnosis. Panama-Buena Vista Union School District procedures require that a clinical psychologist, currently treating the student for the mental health diagnosis preventing school attendance, submit substantiating documentation. **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 Panama-Buena Vista Union School District. Homebound Instruction is determined by the IEP team. The doctor's role is to provide pertinent medical information to P-BVUSD staff so a valid placement may be considered.

Treating Psychiatrist / Clinical Psychologist Statement:

Is the student capable of attending classes on his/her school campus with accommodations to meet their emotional needs? ☐ **Yes** ☐ **No** If yes, please list accommodations: _____

_____

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

If yes, why is the student unable to attend school? _____

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

DSM V Diagnosis and ICD/DSM Code: _____

What medication(s) is/are the student currently prescribed? _____

Is the student a danger to self or others: ☐ Yes ☐ No Explain:

_____

_____

Plan for Student's Return to School (required for student to be considered for Home & Hospital Instruction)
Describe Therapeutic Plan (as implemented by you or therapist): *Please attach a copy.*

_____

Therapist's Name: _____ Phone: _____

Estimated date student may return to school: ___/___/___ (*Not to exceed 90 days from date of request.)*

I am managing the care for this student's current condition. ☐ **Yes** ☐ **No**
I understand that I will be contacted by a member of the school district's health team.

X_____ Date signed _____
Signature of Psychiatrist or Licensed Clinical Psychologist

Physician's Name (Print) _____ License # _____
Phone:_____ Fax:_____ Email: _____
Address_____ City_____ Zip_____