

Mt. Diablo Unified School District

2026-2027 HOME & HOSPITAL INSTRUCTION PARENT/GUARDIAN AGREEMENT FORM

Form 1 of 4

The parent/guardian of the referred student must review and agree to the following requirements:

1. Authorization for Home & Hospital (H&H) instruction by a physician, psychiatrist, or licensed therapist is intended to be at least 15 school days and no more than 90 days before additional authorization is needed to extend instruction.
2. When the student is enrolled in H&H, they will be temporarily disenrolled from their school of attendance and dropped from classes.
3. If the student has an IEP, an IEP team meeting is required before the application to determine whether home instruction is the best instructional setting for the student. A copy of the updated and signed IEP must reflect a change of placement to H&H. It must be signed by all participants, and the meeting notes must accompany the referral. Not all services may be required or offered to provide a Free Appropriate Public Education in the Home Instruction setting. When a student with an IEP returns to the school setting, an IEP meeting must be held to update services for that setting.
4. If the student has a Section 504 plan, a Section 504 meeting is required before application to update the plan to reflect accommodations appropriate for the H&H setting.
5. Students receive 1 hour of home instruction per school subject per week (unless otherwise specified by the IEP team or school administrator), Monday through Friday, by a certificated H&H teacher. No instruction is allowed on days that school is not in session (weekends and scheduled days off).
6. **Home and Hospital Instruction is designed to maintain basic skills and knowledge during temporary illness or disability. Therefore, students will not access content at the same pace as they would in traditional classrooms.**
7. **Middle and High School students who enroll in H&H during a grading period will be issued quarter or semester credits on their transcript by combining the H&H grade with the withdrawal grade from the home school. This may result in a lower grade than the H&H teacher assigns. For example, if the student enters H&H with a drop grade of an 'F' from the home school and the H&H teacher assigns an 'A', the final grade will be blended to a 'C' on the student's report card and transcript.**
8. The H&H program will not support classes such as electives, world languages, AP, IB, honors, lab sciences, Career Technical Education (CTE), or any other subjects requiring hands-on instruction.
9. A parent/guardian must be present during instruction.
10. The student must be ready for instruction at the specified time in a suitable place for learning with appropriate materials.
11. Parents/guardians, not students, should handle communication regarding session rescheduling.
12. Work with your student to ensure they have completed the assigned work before the weekly appointment. Please let the H&H teacher know if there are any concerns with the assignments.
13. If the student is not attending weekly sessions, they may be dropped back to their home school from the H&H program.
14. If the parent/guardian does not authorize an extension of H&H instruction, students may be returned to their home school.
15. The H&H application is only valid for the current school year. A new application must be filled out each school year.

I have read the above statement and understand and agree that these requirements must be met for Home & Hospital instruction to begin and continue. Failure to adhere to the above requirements may result in the student being dropped back to their home school and the discontinuation of Home & Hospital instruction.

HOME & HOSPITAL REQUIRED FORMS MUST BE COMPLETED AND RETURNED TO THE HOME SCHOOL SITE:

- ☐ Form 1: Parent/Guardian Agreement
- ☐ Form 2: Request for Home & Hospital Instruction
- ☐ Form 3: Physician/Psychiatric Referral
- ☐ Form 4: Authorization for Release/Exchange of Information
- ☐ IEP Amendment and meeting notes (if applicable)
- ☐ Updated Section 504 and meeting notes (if applicable)

Student Name: _____

Parent/Guardian Name: _____ Parent/Guardian Signature: _____ Date: _____

Mt. Diablo Unified School District
2026-2027 REQUEST FOR HOME & HOSPITAL INSTRUCTION
Form 2 of 4

Student MDUSD ID#: _____ Last Date of School Attendance: _____ Date of Request: _____

Student's Last Name: _____ First Name: _____ Middle Name: _____

Student Birth Date: _____ Gender: _____ School: _____ Grade: _____

Residence Address: _____
Street City/State/Zip

Parent/Guardian Name(s): _____ Parent/Guardian Preferred Language: _____

Parent/Guardian Email(s): _____ Parent/Guardian Phone Number(s): _____

Reasons for Request (Information will be shared with required staff): _____

Parent/Guardian Name: _____ Signature: _____

TO BE COMPLETED BY HOME SCHOOL SITE

☐ The student has an IEP. Case Manager's Name: _____ Case Manager's Email: _____

☐ The student has a Section 504. Case Manager's Name: _____ Case Manager's Email: _____

Brief History of Disability: _____

Change of Placement IEP/Section 504 Meeting Date: : _____ IEP Amendment/Updated Section 504 Included ☐

Service Provider Information (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy, etc.):

1) Service Provider Name: _____ Type of Service _____

2) Service Provider Name: _____ Type of Service _____

3) Service Provider Name: _____ Type of Service _____

REQUIRED SIGNATURES:

School Site Administrator: _____ Signature: _____

IEP/Section 504 Case Manager Name (if applicable) _____ Signature: _____

Counselor/Therapist (if applicable): _____ Signature: _____

School Academic Counselor: _____ Signature: _____

School Nurse (if applicable): _____ Signature: _____

Mt. Diablo Unified School District

2026-2027 PHYSICIAN/PSYCHIATRIST STATEMENT REQUESTING HOME & HOSPITAL INSTRUCTION

Form 3 of 4

Mount Diablo Unified School District is permitted by law to provide educational services to homebound or hospitalized students only by authorization of a licensed physician, psychiatrist, or therapist. Generally, Home & Hospital Instruction is provided one hour per subject per school day or five hours per week on days school is in session. This should only be used as a temporary placement when medically or psychiatrically required. This service is intended to be provided for a minimum of 15 school days and a maximum of 90 days, as long as the student is under continued medical or psychiatric care and is unable to return to school. Additional authorization is necessary to continue teaching service. The initial education requirement cannot surpass 90 days. This form is only valid for the 2026-2027 school year. The California Education Code requires that a new form be submitted each school year for continued Home & Hospital Instruction.

California Education Code §44873 requires that a licensed California physician or psychiatrist file a statement that includes a medical diagnosis to the extent that the student is unable to attend classes on any school campus. Chronic conditions may not qualify. **You are required to notify our office whether the student's condition has improved sufficiently for them to return to school.** Regardless of the end date, all Home & Hospital Instruction services conclude on the final day of each school year.

Name of Student: _____ Date: _____

The above-named student is unable to attend regular school classes but is requesting Home & Hospital Instruction. My medical and/or psychiatric findings and recommendations are as follows:

Diagnosis (DSM if applicable): _____

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

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

Patient is contagious to the Home Instruction Teacher ☐ YES ☐ NO Explanation: _____

Patient is a danger to themselves or others. ☐ YES ☐ NO Explanation: _____

Limitations, restrictions, or precautions that the Home & Hospital teacher should take when working with this student:

ESTIMATED RETURN DATE TO SCHOOL (15 days to 90 days): Date: (Month/Day/Year) _____

☐ PHYSICIAN ☐ PSYCHIATRIST ☐ THERAPIST

Name: _____ Signature: _____

Office/Specialty: _____ California License Number: _____

Address: _____ City, State, Zip Code: _____

Office Phone: _____ Office Email: _____ Office Fax: _____

Mt. Diablo Unified School District

2026-2027 HOME & HOSPITAL INSTRUCTION AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Form 4 of 4

Physician/Psychiatrist/Therapist Name: _____

Office/Specialty: _____

Address: _____

City, State, Zip Code: _____

Office Phone: _____

Office Fax: _____

Office Email: _____

I hereby request and authorize to release of any relevant medical, social, psychological, and/or test information you may have or may receive about:

Patient/Student Name: _____ Birthdate: _____

The disclosure of this information is required for the following purposes: Home and Hospital Instruction Program Approval, Verification, Updates, etc.

Please direct information to: Kristi Kaufenberg, Home & Hospital Administrator
(925) 685-1011 x 62010
1026 Mohr Lane, Concord, CA 94519

Jessica Pozos, Assistant Director, Mental Health Programs
(925) 682-8000 x4054
1936 Carlotta Drive, Concord, CA 94519

☐ I understand that this consent is valid for 1 year or until the end of the 2026-2027 school year from the date of signing, and that I may revoke this consent at any time by written notice.

☐ I understand that I may request a copy of this authorization for my personal records.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Relationship to Student: _____ Date: _____