PARENT/GUARDIAN LETTER – HOSPITAL INSTRUCTION

TO: Parent/Guardians of Kindergarten-Grade 12 Students Hospitalized in Boundaries of San Diego Unified School District

RE: Hospital Instruction

Dear Parent/Guardian:

If your child is hospitalized in a hospital or other health facility in San Diego, you may request that your child be enrolled in San Diego Unified School District and receive instruction while in the hospital.

The purpose of Hospital Instruction is to support continuity of learning when a student is hospitalized. Instruction is provided by a certificated teacher who will work with your child for up to one hour per day.

California Education Code 48200 requires that children between the ages of 6 and 18 years attend school. It is parent/guardian decision whether to enroll their child in the Hospital Instruction or maintain school enrollment at his or her regular school of attendance.

If you choose for your child to receive instruction in the hospital, he or she will be enrolled in Home/Hospital School, San Diego Unified and be dis-enrolled from his or her regular school of attendance. When your child is able to return to the regular school of attendance, you will need to re-enroll him or her.

To request Hospital Instruction, please complete the attached “Hospital Instruction Request Form” and submit to

Kristina Alicea, Educational Liaison
Home/Hospital and Transition Supports
San Diego Unified School District

Phone: 619-618-9554
Email: kalicea@sandi.net
Fax: 619-344-6447

If you have questions about hospital instruction or educational options for your child during hospitalization, please feel free to contact Ms. Alicea.

Sincerely,

Vanessa Peters, Principal

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REQUEST FOR HOSPITAL INSTRUCTION

SECTION 1: STUDENT INFORMATION. To be complete by parent/guardian.

Student Name _______________________________    __M   __F    Date of Birth ____/____/____   Grade ________________

Parent/Guardian Name _________________________________________________________________________________

Address _______________________________________     City____ __________________Zip____________

Home Phone (_____) ______________________  Mobile Phone: (____) ____________________________

Current School District ______________________________    Current School _________________________________

Student’s last date of attendance ___/___/___

Does your child have an IEP? __yes  ___no?      Does your child have a 504 Plan? ___yes  ____no

Name of hospital: ______________________________________________________________

Authorization to Receive/Release Medical and Academic Information for Educational Purposes. As the parent or legal guardian of the above named student and by my signature above, I authorize the San Diego Unified School District and the Physician identified below to release and exchange medical information relative to the above named student so eligibility for home/hospital (H/H) teaching services can be determined. I certify I am aware that I may request to review any requested records and may receive a copy of any materials exchanged. The information received will be used only to assist the San Diego Unified School District in determining eligibility for Home/Hospital teaching services for the above named student. It will not be copied for transmission to others without parent or guardian authorization.

X____________________________________ _______________________  __________
Parent/Guardian’s Signature      Relationship        Date

SECTION 2: PHYSICIAN’S STATEMENT

PHYSICIAN. Temporary Home instruction is provided to students unable to attend school for temporary reasons that are related to illness or injury. Students with long-term disabilities may be referred for special education evaluation. The California Education Code 44873 requires that a licensed California physician or licensed clinical psychologist provide written justification, including a medical diagnosis. If educational services are authorized at this time, please complete, this section, sign below and return this form to parent/guardian or hospital teacher.

Diagnosis or ICD/DSM Code: _________________________________________________________

Precautions/Restrictions applicable for bedside/classroom teaching: _________________________________________________

Is student’s condition contagious? ___Yes ___No

Admission date:________________________                                       Estimated Discharge date:_________________

Physician’s Signature_____________________________ M.D.         Date_______________________

Physician’s Name (print) ____________________________ M.D.        Phone: (___) _______________

Address __________________________________ City______________________ Zip___________

Please submit completed form to Ms. Kristina Alicea, Educational Liaison
by Fax: 619-344-6447 or email, kalicea@sandi.net.

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