Hospital Instruction

Important Information for Parents/Guardians

Purpose of Hospital Instruction.
The purpose of hospital instruction is to provide educational services in the hospital to a student with a temporary illness or injury to help the student maintain their academic performance during recovery. San Diego Unified School District requires that a licensed California physician or licensed clinical psychologist provide written justification, including a medical diagnosis, indicating the extent to which the student can attend school.

Questions Regarding Educational Options. Children who are admitted to a hospital or other health facility within the boundaries of San Diego Unified School District (SDUSD) are eligible to enroll in hospital instruction. Although California Education code 48200 requires that children between the ages of 6 and 18 years attend school, it is a parent/guardian decision to enroll their child in SDUSD hospital instruction or maintain school enrollment at his or her regular school of attendance. If you have questions regarding school options, please contact:

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

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

Enrollment in Home/Hospital & Transition Supports School. If you choose for your child to receive instruction in the hospital, he or she will be disenrolled from his or her regular school of attendance and temporarily enrolled in the Home/Hospital & Transition Support School. Hospital instruction will end upon discharge from the hospital. When your child is able to return to the regular school of attendance, you will need to re-enroll at that site.

Delivery of Hospital Instruction. While the student is hospitalized, five hours of instruction per week will be provided, typically scheduled for one hour per day. Instruction is provided by a certificated teacher.

If interested in receiving hospital instruction, please complete the attached request form.

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

Additional information regarding services provided by the Home/Hospital and Transition Supports School can be found at www.sandi.net/Page/44779
REQUEST FOR HOSPITAL INSTRUCTION

Name of Hospital: ____________________________ Floor or Room Number: _____________

STUDENT INFORMATION
Last Name _______________________________ First Name _______________________________ Gender □ M □ F
Date of Birth ____/____/____ Student/Parent Language ___________________________ / ______________________
Address________________________________ City____________________ Zip ________________
Contact Information: Phone Number (___) ______________________ Email ______________________
Parent/Guardian Name (please print) ___________________________ __________________________
After discharge, is homebound instruction anticipated to be needed for 2 weeks or longer prior to returning to school? □ Yes □ No

SCHOOL INFORMATION
Current School District _________________________ Current School ___________________________ Grade ______
Student’s last date of attendance ____/____/___ Teacher / Counselor _________________________________
Does your child have an IEP? □ Yes □ No Does your child have a 504 Plan? □ Yes □ No □ Copy attached
Class schedule for middle and high school students. Must be filled in:
Period 1: _____________________________________________ Period 4: ___________________________
Period 2: _____________________________________________ Period 5: ____________________________
Period 3: _____________________________________________ Period 6: ____________________________

Implementation of Services
- Home/Hospital and Transition Supports School will provide five (5) hours of instruction per week in a manner consistent with California laws governing home/hospital.
- Instruction is generally offered in two (2) content areas.
- The student will be temporarily disenrolled from his/her regular school of attendance during the period he/she is receiving home/hospital instruction.

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 below, I authorize the current school/district of enrollment, San Diego Unified School District (SDUSD) and the treating physician, and/or licensed clinical psychologist, to release and exchange medical and/or academic information relative to the above named student. The information received will be used only to assist SDUSD in determining eligibility, appropriate services, academic needs, and transitions between educational sites for the above named student. I certify I am aware that I may request to review any requested records and may receive a copy of any materials exchanged.

X ___________________________ ___________________________ _____________
Parent/Guardian’s Signature Relationship Date
Student Name ___________________________ DOB ________________

SECTION 2: PHYSICIAN’S STATEMENT

PHYSICIAN: A request for hospital Instruction has been made for the above-named student. SDUSD Procedures require that a licensed California physician, the treating physician, and/or licensed clinical psychologist currently treating the student for this condition, file a statement, which includes a medical diagnosis, and indicate at this time if educational services are authorized.

Diagnosis: __________________________________________________________
________________________________________________________
________________________________________________________

Is student’s condition contagious? □ Yes □ No

Limitations, restrictions, or precautions the teacher should take in teaching this student: ________________________________
________________________________________________________
________________________________________________________

Admission Date ___________________ I estimate this student will be hospitalized until ___________________ (Specific date required)

Physician’s Signature ________________________________ M.D. Date ______________________

Physician’s Name (Print) ________________________________ M.D.

Phone: __________________________ Fax: __________________________ Email: __________________________

Address __________________________________ City ____________ Zip ____________

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