POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
800 S. Garey Ave., Pomona, CA 91766
Phone (909) 397-4648, Ext. 28357 Fax (909) 469-6192

HOME AND HOSPITAL APPLICATION

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION 1: THIS SECTION TO BE COMPLETED BY PARENT

Date:_____ Parents Signature: _____

This form and parental signature authorizes the attending physician to share information with school personnel for the purposes of determining appropriate educational services for the student named below.

Student:_____ Birthdate: _____

School of Attendance:_____ Grade:_____

Parents: _____

Street Address:_____ Phone: _____

City/State:_____ Zip code:_____

SECTION 2: THIS SECTION MUST BE COMPLETED BY THE DOCTOR

Dear Doctor,

In order to provide a home teacher for out of school instructional services we must have a request from you for a minimum period of four weeks. We also must have a complete diagnosis of the child's ailment. The illness cannot be a contagious disease.

Additionally, we might need to consult with you regarding other available school programs, which might better fit the needs of the student, such as the School of Extended Educational Options (SEEO).

☐ SEEO Option discussed with parent & student

Diagnosis:_____

Length of time expected to be in need of a home teacher: _____

Beginning:_____ Ending: _____

Hospitalization Length:_____

Name of hospital:_____

Beginning:_____ Ending:_____

Additional information: _____

_____

Physician Name: _____
(Please Print)

Address:_____
(Please Print)

Phone:_____ Fax number:_____

Physician Signature:_____ Date:_____

If you have any questions, please feel free to call. <u>Return this form to School Nurse.</u>

SECTION 3: THIS SECTION TO BE COMPLETED BY SCHOOL NURSE

Nurse Notes: ☐ Approved ☐ Review Requested Nurse's Signature: _____

Administrator Approval:_____ Date_____