BONITA UNIFIED SCHOOL DISTRICT

115 West Allen Avenue San Dimas, California 91773 (909) 971-8200 Fax (909) 971-8329

Student Name _____ **DOB** _____

Current School _____ **GR** _____

Home and Hospital instruction is provided for students with a **temporary** medical condition from which recovery and return to original school program is expected**. It is usually reserved for students who have conditions which prohibit them from leaving the house except for medical appointments** or during an **initial** phase of medical/psychiatric treatment. ALL home hospital requests must be also authorized by a Credentialed School Nurse and/or District Administrator.

The authorization will be subject to review after **45 calendar days**. A new authorization form may be required.

MEDICAL REFERRAL FOR HOME AND HOSPITAL INSTRUCTION
(Section to be completed by a Licensed California Physician)

Medical Section: The California Education Code §48200 states that each person who is between the ages of six and eighteen years is subject to compulsory full-time education. The California Education Code §44873 requires that a licensed California physician provide a medical statement which excuses a student from attending regular school.

Student's Medical/Psychiatric Diagnosis requiring home instruction:

_____

Is there a treatment plan? ☐ Yes ☐ No
Summary of Therapeutic Plan:

_____

_____

_____

Are medication(s) prescribed as part of the treatment plan? ☐ Yes ☐ No
List:

_____

_____

What is the severity, prognosis or nature of the problem?

_____

_____

_____

Is the student unable to leave the home for anything other than Doctor's appointment? ☐ Yes ☐ No

What aspects of the treatment plan are being implemented to enable the student's return to school?

_____

_____

_____

Estimated date student may return to school: _____

Beyond the forty-five (45) day time period, a new completed referral may be required for services to continue. For renewal period, school district procedure requires a mental health treatment plan be confirmed by a treating Mental Health practitioner.

Physician's Signature _____ M.D. Date____/_____/_____

Physician's Name (Print) _____ M.D.

Phone ( ) _____ FAX ( ) _____

Note:

Thank you for your cooperation. All home hospital placements must be approved by a School Nurse and/ or District Administrator.

Approval(s):

_____	_____	_____	_____
Credentialed School Nurse	**Date**	**District Administrator**	**Date**

Rev/08/13rs

BONITA UNIFIED SCHOOL DISTRICT
AUTHORIZATION FOR DISCLOSURE OF MEDICAL AND/OR EDUCATIONAL INFORMATION

Name of student (list other names used)	*Medical Record Number (if applicable)*	*Date of Birth*
Address of student	*Phone No.*	*Other Phone No.*

I, _____, authorize the Bonita Unified School District _____ to:
[name of Student/Student's Rep] [Name of Educational Agency]

X Release the above-named individual's ***medical***/educational Information as identified below **to:**

Individual or Organization Receiving Information

_____
Receiving Party
_____
Address
_____
City, State, Zip Code
_____
Telephone/Fax

X Obtain the above-named individual's ***medical***/educational information as identified below **from:**

Individual or Organization Receiving Information

_____
Receiving Party
_____
Address
_____
City, State, Zip Code
_____
Telephone/Fax

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature if no date is entered.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the ***disclosing*** agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Redisclosure: I understand that medical/educational information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it ***may*** no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

Health Info: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment.

Specify Record(s): Indicate type of information that is to be disclosed.

☐ Medical Information ☐ Medication Information ☐ Psychiatric Information ☐ Mental Health
☐ Drug/Alcohol Information ☐ Educational Records ☐ Other: _____

Qualification for consideration of education services is dependent upon a qualifying diagnosis by the disclosing party.

I request that the information released pursuant to this authorization be used for the following purposes only:

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

A copy ***or facsimile*** of this authorization is as valid as an original.
I understand that I have a right to receive a copy of this authorization for my ***or my child/ward's*** records.
I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.

Signature of Student or Student's Representative	*Description of Relationship to Student*	*Date*

NOTE: Original signature is required for release of medical information. No facsimile of this form will be accepted when requesting the disclosure of medical information.
Rev/08/13rs