A COPY OF IMMUNIZATION RECORDS SHOULD ACCOMPANY THIS REFERRAL

LOS ANGELES UNIFIED SCHOOL DISTRICT

Carlson Home Hospital School

10952 Whipple St., No. Hollywood, CA 91602
Phone: (818) 509-8759 FAX: (818) 505-0246

HOSPITAL MEDICAL REFERRAL

CARLSON HOSPITAL TEACHER: _____ _____
Print Name Print Site Name

Patient/Student Information

Last Name_____ **First Name**_____ ☐ **M** ☐ **F**

DOB_____/_____/_____ **Gr.** _____ **Student Language**_____ **Parent/Guardian Language** _____

Address _____ **City**_____ **Zip**_____

Home Phone ( ) _____ **Cell Phone** ( ) _____ **Work Phone** ( ) _____

Parent/Guardian _____ **Parent Email Address** _____

Do you have Internet Access? ☐ **Yes** ☐ **No** **Student Email Address** (Gr. 6/7-12)_____

School of Attendance _____ **Phone** ( ) _____ **Last date of attendance** _____

School of Residence _____

Does student have a current IEP? ☐ **Yes** ☐ **No** **Eligibility**_____ **Does student have a current 504 Plan?** ☐ **Yes** ☐ **No**

IMPLEMENTATION OF SERVICE

HOSPITAL TEACHING - Hospital Instruction will be provided in a manner consistent with California laws governing home hospital teaching. Instruction is offered in two (2) basic subject areas unless additional courses are approved by a Carlson administrator.

By signing this authorization for service, the parent/guardian is agreeing to the following:

- If the student is eligible, educational services will be temporarily provided by the Carlson Home Hospital School.
- The student will be temporarily disenrolled from his/her regular school of attendance (cumulative record carrying school) during the period he/she is receiving home instruction. Grades and marks will be reported to the cumulative record carrying school.
- Educational information will be accessed and used to plan and provide an appropriate educational program for the student.
- Permission to provide services or access school records may be revoked via written parent/guardian request at any time.
- Carlson provides hospital instruction between the hours of 8:00 a.m. and 3:00 p.m. No specific schedule nor teacher can be guaranteed.

PARENT/LEGAL GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL AND ACADEMIC INFORMATION AND TEMPORARILY TRANSFER EDUCATIONAL DUTIES:

Parent Signature_____ **Date** _____

The Hospital Attending Physician or Psychiatrist must complete page 2 to authorize service

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HOSPITAL MEDICAL REFERRAL

Student Name _____ **D.O.B** _____

PHYSICIAN: A request for Hospital Instruction has been made for the above-named student. If educational services are authorized at this time, please complete, sign below and return this form to the Hospital Teacher or Carlson Office.

Attending Physician's / Psychiatrist's Statement

Diagnosis for ICD/DSM Code:_____

Summary of Medical Problem/Therapeutic Plan: _____

_____

_____

Precautions/Restrictions applicable for bedside/classroom teaching:_____

_____

_____

Is student in ICU? ☐ Yes ☐ No **In Isolation?** ☐ Yes ☐ No Type_____

Is student's condition contagious? ☐ Yes ☐ No

This section to be completed by a California licensed physician or psychiatrist:

Admission Date _____ **Estimated Discharge Date** _____

Signature _____**MD** **Signature Date**_____

Print Name _____ **Phone** ( )_____

Print Title _____ **Fax** ( )_____

Address _____ **City** _____ **Zip** _____