HOMEBOUND/HOSPITAL SERVICES

501 E 3900 S • SALT LAKE CITY UT, 84107

Parent Release of Information

Notes to Parents/Guardians:

1. Your signature on this form authorizes the release to Granite School District of medical and other information regarding your child's diagnosis, limitations, and other data necessary to serve your student in the Homebound/Hospital Program.

2. Your signature on this form authorizes Granite School District to release and discuss information about your student to health care providers.

3. **Return this completed form along with the Physicians Recommendation form to the elementary school or the junior/senior high school.** The school's **Student Support Team and/ or IEP Team** will review the forms and, if they approve the referral, they will forward the referral and these forms on to the Homebound/Hospital office. We will then assign a teacher to contact you and arrange to begin the home instruction.

Parent/Guardian Release of Information

Student's Full Name (please print):	Parent's Name:	D.O.B	Phone Number 1:
Phone Number 2:	Phone Number 3:	Email Address:	
Street Address:			

I, the undersigned, authorize the release of any and all medical, psychological and other related professional information and reports regarding the above-named student to Granite School District and authorize Granite School District to release information and reports to those providing medical, psychological and other related information.

Parent's/Guardian's Signature: Date:

HOMEBOUND/HOSPITAL SERVICES
PHYSICIAN'S RECOMMENDATION

STUDENT NAME ______________________

D.O.B ______________________

Notes to the attending licensed physician or licensed mental health professional:

1. The Granite School District Homebound/Hospital Program provides temporary home instruction for students whose current state of health renders them unable to attend school.
2. Please fill out the requested information completely and legibly and sign at the bottom. By doing so, you help us avoid delaying educational services to the student.
3. For those students requiring long-term homebound/hospital services, a new and updated Physician's Recommendation form will be required **every 9 weeks** (unless more frequent physician's recommendations are requested by the school Student Support Team).

I. The undersigned licensed physician or licensed mental health professional certifies that the above named student is excused from attending school ☐ Part-Time ☐ Full-Time for the following reason(s):
(Diagnosis)______________________
(Limitations of school participation) ______________________

II. Medications/Side Effects: ______________________

III. Does the student's condition allow participation in physical education? ☐ **YES** ☐ **NO**

IV. Can the student receive instructional services without endangering the health and safety of the instructor or other students with whom the instructor may come in contact? ☐ **YES** ☐ **NO**

V. Is the student receiving on-going treatment/therapy? ☐ **YES** ☐ **NO**

If YES, please indicate the frequency of treatment/therapy______________________

VI. Expected number of weeks the student will be out of school (required):

☐3 Weeks ☐4 Weeks ☐5 Weeks ☐6 Weeks ☐7 Weeks ☐8 Weeks ☐9 Weeks

- **Durations of less than 3 weeks (15 school days) will not be approved for homebound/hospital instruction and the student will be referred to the school for accommodation.**
- **Durations of more than 9 weeks require a new/updated Physician's Recommendation form after 9 weeks.**

VII. Other mitigating or relevant information (attach a sheet if needed): ______________________

Please note: A member of the School Student Support Team may contact the physician/therapist to discuss other education options.

Name of Licensed Health Professional (please print):	Degree:	Phone Number:
Street Address:	Email Address:	
*Signature:		Date:

***Signature of licensed attending health professional only please.**

RETURN TO STUDENT'S SCHOOL

Fax #: ______________ Contact: ______________ Contact Info: ______________________

HOMEBOUND/HOSPITAL SERVICES

SST RECOMMENDATION FORM

PHONE:385.646.6040 FAX:385.646.5440

Student:	Student #:	Grade:	Date:
School:	Name of SST contact person:		
Name of parent/guardian:	Date of meeting with parent/guardian:		

Please note: Home Hospital referrals less than 3 weeks (15 school days) will be referred back to the school for accommodations.

I. What interventions could/should be tried before referring to Home Hospital (Example: referral to social worker/psychologist, school nurse, part-time schedule, 504, online/blended courses, referral to Connection High, etc.) ________________________

____

II. What other interventions/accommodations are currently in place that Home Hospital needs to be aware of. (Example: 504, referral to social worker/psychologist, school nurse, part-time class schedule, PT/OT, etc.) ____________________________

____

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III. Our Student Services Team has determined that Home Hospital is the appropriate placement for this student?

☐ **YES** ☐ **NO**

☐ **Full-Time** ☐ **Part-Time**

IV. Is there a teacher at your school who would like to be the Home Hospital Instructor?

☐ **YES** ☐ **NO** **Teacher Name** ______________________

V. Does this student have a current IEP? ☐ **YES** ☐ **NO**

a. All Home Hospital referrals for students with an IEP <u>MUST</u> be approved by a district Special Education Coordinator <u>BEFORE</u> submitting the referral to Home Hospital.

Name of District SPED Coordinator consulted:____

VI. What courses do you want Home Hospital to teach?

☐ Packets (paper)

☐ Online

☐ Hybrid of Packets & Online

Course Number	Course Title

Please note: some courses may not be available through Home Hospital.

SST SIGNATURES:

LEA (Lead Education Admin): ____________________________

Counselor: ____

Social Worker/Psychologist: _____________________________

Special Ed Representative: ______________________________

School Nurse: ____

Other: ____

Other: ____

Other: ____

Attach copy of transfer grades.

Granite School District
STUDENT SUPPORT FORM

Initiated by: ☐ Parent ☐ School
Concern: ☐ New ☐ Continuing

Version 03/2019

Student: ________ Student ID: ________ DOB: ________ Date: ________

School: ________ Grade: ____ Teacher: ________

Form completed by School Representative: Name: ________

☐ Administrator ☐ Counselor ☐ School Psychologist ☐ Social Worker

Parent/Guardian: ________ Home Address: ________

Current Phone: ________ Alt Phone: ________ Email: ________

Preferred Contact: ☐ Email ☐ Phone Call ☐ Text

Concern(s): ☐ Academic ☐ Behavioral ☐ Attendance ☐ Social/Emotional ☐ Medical ☐ Other

How has/will concern(s) be addressed?

☐ Adequate information/documentation has been provided. Follow up as needed.

☐ More information/documentation is needed.

☐ Date proposed to review with Student Support Team: ________

Parent/Guardian Signature: ________ **Date:** ________

School Representative Signature: ________ **Date:** ________

Continuum of Services Disclosure: The parent/guardian acknowledges that they have discussed, with the educator, Granite School District's continuum of educational services (*e.g., core instructional programs and options, advanced learning options, academic interventions, behavior interventions, English Language Learning options, 504 Accommodations, Special Education, etc.)*.

Parent Initials: ________

Suicide Prevention Disclosure: The parent/guardian has received a list of additional resources in accordance with state law and parents have been informed about lethal means safety.

Parent Initials: ________ ☐ N/A