DIRECTIONS TO FAMILIES REQUESTING HOME/HOSPITAL INSTRUCTION

Home/Hospital tutoring is a service provided to students who are medically unable to attend school for a **minimum of 4 weeks and a maximum of 18 weeks** because of a physical disability or illness. The program does not provide tutoring to students caring for an infant or a relative who is ill.

More information can be found in the Parent's Guide to Home/Hospital Services brochure which can be obtained from your child's counselor or school nurse.

Please provide the following forms to your Heath Care Provider to document eligibility for services:

1. Directions to Health Care Provider Requesting Home/Hospital Instruction
2. Request for Home/Hospital Instruction
3. HIPPA Authorization for Release of Medical Information

Your Health Care Provicer should fax the forms and any additional required information to:
253-841-8655
ATTN: Home/Hospital Coordinator

Tutoring services will be arranged only after all forms are received from the health care provider and eligibility for the service has been established.

If it is foreseeable that a your child's illness would require them to be home on an intermittent or long-term basis that does not meet the guidelines for H/H services (e.g. partial days; several days a week; unpredictable days based on student condition or treatment plan; beyond 18 weeks), all documentation received will be forwarded to the 504 coordinator at the student's school.

If you have additional questions, please call Tracy Pitzer at 253-841-8700.

214 West Main, Puyallup, Washington 98371
Telephone: (253) 841-8700 FAX: (253) 841-8655

What to expect when my child is receiving Home/Hospital tutoring:

Home/Hospital Tutor Responsibilities:

- To arrange with parents for two one-hour tutoring sessions per week
- To contact school staff about class assignments
- To gather and take assignments to student's home
- To provide tutoring assistance and guidance to student
- To provide feedback and return any completed schoolwork to teachers
- To consult with parents on student's progress

School Building Staff Responsibilities:

- To provide assignments, textbooks, and related materials in a timely manner
- To make accommodations and modifications, as needed, on assignments
- To generate print-outs of missing work and grade status
- To correct and grade returned assignments
- To inform building attendance secretary of any known changes in absence status

Student Responsibilities:

- To work at least three hours per day on assignments
- To complete assignments in a timely manner
- To be prepared to work at scheduled tutoring session times
- To ask for help or clarification

Parent Responsibilities:

- To have an adult in the home during scheduled tutoring session times
- To provide a clean, quiet work area
- To support student in meeting his/her responsibilities

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REQUEST FOR
HOME/HOSPITAL INSTRUCTION

SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle) Please Print	
Puyallup School District			
CONTACT PERSON	TELEPHONE NUMBER	STUDENT DOB	GENDER
Tracy Pitzer	253-841-8700		☐ Male ☐ Female
	FAX NUMBER 253-841-8655	STUDENT GRADE LEVEL	

SECTION 1—THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

DIAGNOSIS:

☐ Disease/Injury/Surgery (primary diagnosis):_____

☐ Drug/Alcohol Treatment
☐ Pregnancy
☐ Other* (describe): _____

* Diagnosis such as "mental illness", "anxiety neurosis" and certain other illnesses which are manifested by severe behavioral problems will require an accompanying letter consisting of the diagnosis, a brief plan of care, prognosis, etc.

I certify that this student is unable to attend public school for _____ weeks ☐ continuously ☐ intermittently**.

TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER

BUSINESS ADDRESS

SIGNATURE DATE

CONTACT TELEPHONE NUMBER

SECTION 2—THIS SECTION FOR SCHOOL DISTRICT USE

If the student is eligible to receive special education services, does the IEP team need to meet? ☐ Yes ☐ No

CHECK ONE

☐ Original Request
☐ Extension

Beginning date of instructional time or extension: MO | DAY | YEAR

NOTE: Beginning date on extension request must consecutively follow ending date of original

SCHOOL DISTRICT AUTHORIZATION DATE

CONTACT TELEPHONE NUMBER

* * If it is foreseeable that a student's illness would require them to be home on an intermittent or long-term basis that does not meet the guidelines for H/H services (e.g. partial days; several days a week; unpredictable days based on student condition or treatment plan; beyond 18 weeks), all documentation received will be forwarded to the 504 coordinator at the student's school.

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Puyallup Special Services -- School District
214 West Main, Puyallup, WA 98371
Phone: (253) 841-8700 Fax: (253) 841-8655

Patient Information:

_____ _____ _____
(PRINT name of patient) Date of Birth SS#

Information to be released from: _____
Name of designated Facility or Provider

_____
Address

_____
City, State, Zip Code

_____
Fax Number Phone Number

Information to be sent to:

PUYALLUP SPECIAL SERVICES
214 W MAIN
PUYALLUP, WA 98371

Confidential Fax (253) 841-8655

Information Requested by: _____

Information (✓) to be released:

- ❑ The most recent 2 years of pertinent information (Chart notes, labs, x-rays and special tests)
- ❑ All medical records
- ☑ Specific information (Please specify): *Information to assist with educational planning and placement*

The disclosure of this medical information is for educational evaluation and planning.

Patient Authorization:

I understand that these records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial):

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Mental Illness or Psychiatric diagnosis/treatment
_____ Sexually Transmitted Disease _____ HIV/AIDS diagnosis/treatment/testing

I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying Puyallup School District Schools in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

SIGNATURE: _____ DATE: _____
(Patient, Guardian*, or Authorized Representative -- *Please provide documents to prove authority to sign on behalf of the patient.

This authorization will expire 90 days from the date signed

This release covers the date range of _____ to _____.