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 Provider 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 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 Lisa Rodside at 253-841-8700.

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

REQUEST FOR
HOME/HOSPITAL INSTRUCTION

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

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

____
SIGNATURE DATE

BUSINESS ADDRESS

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.

PUYALLUP SCHOOL DISTRICT — HEALTH HISTORY

NAME: DOB: GRADE: DATE:

PARENT/GUARDIAN: RELATIONSHIP TO STUDENT:

LIFE THREATENING CONDITIONS

Does your child have a life threatening health condition?
Yes**______ No _______
Specify____
*****If yes, you must schedule a meeting with the School Nurse prior to student starting school.*** **Washington State Law requires that a medication, treatment, and/or healthcare plan is in place prior to starting school.**
Does your child have a current Emergency Action Plan and/or 504? ____________________________
Does your child ride the bus? Yes___ No ___Route #_____

HEALTH CONCERNS

Have you ever been told by a health care professional that your child has:

____**ADD/ADHD** (circle one)
____**Allergies** Type________________________________
Medication required **Yes***___ No___ Type___________
Describe reaction_________________________________
____**Asthma** Uses inhaler **Yes***______ No______
Exercise induced Yes_______ No______
____**Bowel/Bladder Issues** Type ____________________
____**Diabetes** ***Meeting with the School Nurse is required***
____**Dental Issues** Type_____________________________
____**Drug/alcohol treatment** Year___________________
____**Emotional Concerns** (circle)
Depression/ Anxiety/Eating Disorder/Other__________
____**Frequent cold/sore throats/earache** (circle)
____**Headaches** Frequency__________________________
____**Head injury** Concussion Yes_______ No________
Date________ Lost consciousness Yes_____ No_____
____**Hearing** (circle) Aids Preferential Seating Tubes
____**Heart Condition** ____________________________
Restrictions/Limitations ___________________________
____**Major Illness/Surgery/Hospitalization** Year______
Describe ____
____**Neurological conditions**______________________
____**Nose bleeds** Frequency _______________________
____**Other bleeding conditions**____________________
____**P.E .Limitations**_____________________________
For what reason? __________________________________
____**Seizure Disorder** Describe type_________________
Last seizure ______________________________________
____**Skin Condition** _____________________________
____**Speech Difficulty/Therapy** (circle)
____ **Stomach aches/cramps/tires easily** (circle)
___ **Vision Problem** Contacts ________Glasses_________
Reading _______ Distance _______ Both____________
____**Other Concerns**
____
____

MEDICATION

Does your child take any medication? Yes _____No______
If Yes, name of medication___________________________
Purpose: ______________________________________
Will the medication be needed at school? **Yes***____No____
***For medications to be administered at school, Washington State Law and District policy #3416 requires a written Physician's Order for Medication and parent permission to be completed each school year.**

DEVELOPMENTAL HISTORY

Was there a health problem/handicap at birth?
Yes/No Please describe: __________________________
Normal Pregnancy: Yes/No Normal Delivery: Yes/No
If no, explain: _____________________________________
Birth Weight: _________ Talked words (age)___________
Walked (age) _________
Do you feel your child's development has been equal to other children's? Yes/No If No, why not?
____

Do you have concerns about your child's hearing, vision, or speech? Yes__ No__ Specify________________________
Last medical exam: Date: _______ Provider: ____________
Last eye exam: Date: _______ Provider: ____________
Last Dental exam: Date: _______ Provider_____________
Does your child have medical insurance? Yes____ No_____
Does your child have dental insurance? Yes____ No______
Is your child covered by Medicaid? (Healthy Options, DSHS, "medical coupons") Yes____ No____
Is there any other health related information that school staff should know?
____
____

Washington State Immunization Law 28A.31.118 requires that a Certificate of Immunization be completed for each child attending school or day care center.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of medical emergency, I authorize and direct school staff to send my child to the most accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

____
Parent/Guardian Signature Date

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 ______________.