SECTION I: STUDENT DATA

State of Hawaii
DEPARTMENT OF EDUCATION
Office of Curriculum, Instruction and Student Support
Student Services Branch

REQUEST FOR HOME-HOSPITAL INSTRUCTION SERVICES

INSTRUCTIONS:

1. The requester completes "Section I: Student Data" and obtains signature of parent(s)/legal guardian(s).
2. The licensed physician completes "Section II: Physician's Verification."
3. **The requester submits completed form to school**.
4. The school completes Section III. Principal signs Section III D.
5. The school submits copies to parent/legal guardian and to the **respective District Office.**

Please type or print legibly.

Student's Name: _____
Last First MI

School: _____

Grade: _____ Birthdate: _____ Student ID#: _____

Regular Education: ☐ Section 504: ☐ Special Education: ☐

Mother's Last Name, First Name:	Father's Last Name, First Name:	Legal Guardian's Last Name, First Name:
Home Phone #:	Home Phone #:	Home Phone #:
Cell Phone #:	Cell Phone #:	Cell Phone #:
Work Phone #:	Work Phone #:	Work Phone #:
Emergency Contact Name :	Relationship to Student :	Emergency Contact Phone #:

CONSENT FOR RELEASE AND DISCUSSION OF HEALTH INFORMATION

☐ I give my consent to release and discuss health information pertinent to my child's condition between the school, the licensed physician, licensed psychiatrist, licensed psychologist, and the Department of Health Public Health Nurse.

☐ I **do not** give my consent to release and discuss health information pertinent to my child's condition between the school, the licensed physician, licensed psychiatrist, licensed psychologist, and the Department of Health Public Health Nurse. I understand that by not giving consent, the HHI request may be denied.

Signature: _____ Date: _____
Parent(s)/Legal Guardian(s)

Address: _____ Phone: _____
Street City State Zip Code

Requested By: _____ _____
Name Relationship to Student

SECTION II:
LICENSED PHYSICIAN'S, LICENSED PSYCHOLOGIST'S, OR LICENSED PSYCHIATRIST'S VERIFICATION

INFORMATION REGARDING THE NATURE OF STUDENT'S MEDICAL/MENTAL HEALTH CONDITION PROVIDED BY THE STUDENT'S LICENSED PHYSICIAN, LICENSED PSYCHOLOGIST, LICENSED PSYCHIATRIST

Student's Legal Name: _____ Date of Birth: _____

Please check applicable boxes below and complete requested information.

☐ The student has a physical/mental health condition that requires the student to be confined to his/her home or hospital for a minimum of ten (10) consecutive school days;

Briefly describe the nature of student's temporary physical/mental health condition that requires student to be absent from school for a minimum of ten (10) consecutive school days and to receive Home Hospital Instruction Services:

☐ physical/medical _____

_____

_____

☐ psychological _____

_____

_____

Is this student **able** to function for a shortened day or with other accommodations? ☐ Yes ☐ No

If the student **is able** to function for a shortened day, are there any restrictions? ☐ Yes ☐ No

If the student **is able** to function for a shortened day, please describe restrictions:

_____

_____

_____

Does the student have a communicable disease that poses a risk to the homebound tutor of becoming infected or carrying it to another student? ☐ Yes ☐ No

Based on my examination, the above named student **has** a serious, acute illness, injury or long-term medical condition such that the student is unable to attend school. ☐ Yes ☐ No

If yes, the above named student is not able to attend school for _____ weeks.
Expected return to school date: _____

_____ _____
Signature of Licensed Physician/Psychiatrist/Psychologist Date

_____ _____
Print or type: Licensed Physician/Psychiatrist/Psychologist Name Title

Address: _____
Street City State Zip Code

Phone Number: _____

SECTION III: SCHOOL ACTION

A. TUTORIAL ASSISTANCE TO BE PROVIDED: (Note: Additional pages may be attached as needed.)

Subject Area	Description of Class Assignments, Assessments, and Due Dates	Instructional Materials (School will provide required instructional materials.)

Explain any instructional adjustments necessary: _____

_____

B. TRANSITION PLAN (to be developed prior to the commencement of services):

_____

_____

_____

C. TUTOR:

Name: _____ Phone: _____
Last First MI

Total number of hours of tutorial assistance per week: _____

Beginning date of tutorial assistance: _____ Ending date of tutorial assistance: _____
(Determined Prior to Commencement of Services)

NOTE: Services will only be provided if a parent or legal guardian, or an adult, authorized in writing by the Parent(s)/legal guardian(s), is present for the duration of tutorial sessions. Sessions must be conducted in the home or hospital setting.

D. PRINCIPAL/DESIGNEE APPROVAL/DISAPPROVAL:

_____ Date: _____
Signature of Principal/Designee

Approved: ☐ Disapproved: ☐ Reason disapproved: _____

Student Return Date: _____ _____
Determined prior to commencement of services.

DISTRICT OFFICE ACTION *(for Official Use Only)*

Date HHI request received: _____ **HHI start date:** _____ **Database entry date:** _____

Distribution: School, District Office, Parent(s)/Legal Guardian(s)