Fresno Unified School District

Preparing Career Ready Graduates

Home and Hospital Instruction
DPI/Project ACCESS
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HOME & HOSPITAL INSTRUCTION (HHI) APPLICATION
2019-2020 School Year

For Parent/Guardian:

Student Name____Birth Date ____________

Address ____________________________________Zip Code _________ Phone ______________

I understand that the HHI & school site may review the information provided on this form.

I hereby authorize this team to have access to my child's medical information as it relates to this application.

Parent/Guardian's Name (print) ________________________ **Signature:** _____________________

Date _____________ **Parent/Guardian Spoken Language** _________________________________

Parent Email Address ____

For School Site:

School Site ____________________________**Student Grade:** _________ **Student ID#** ____________

Counselor:______________________________ **Vice-Principal:** ____________________________

Nurse: _____________________ **Special Ed: Yes** __**RSP/SDC NO** ___ **Case Manager:** ____________

IEP is required for change in placement status for SPED students requesting HHI. Completion of application does not guarantee placement in HHI. A 3-week minimum is required for HHI placement with no more than one semester approval at time of application.

To Attending Physician of above listed student:

Please fill in each section completely.

By law, FUSD may provide educational services to homebound or hospitalized students only on authorization of a licensed physician. ***This program should only be used as a temporary or last resort***. Home Hospital Instruction requires the student to be homebound, meaning the treating physician requires the student to remain at home, with **no outside activities** due to the fragile nature of their current medical condition.

This student is recommended for Home/Hospital Instruction.

The health diagnosis is: ____

Please list the specific reason the student is unable to attend school, understanding that FUSD has a legal duty to provide education for all students and would utilize the least restrictive environment.

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____

Summary of Therapeutic Plan: ____

____

How long has this patient been in your care?__________________**Are appointments kept? Yes No**

Additional Remarks/Comments: ____

____

Expected date to *return to school* is ____________**.** Is the teacher at risk of contagion or physical harm? Yes No

________________________________ ____________________________ ____________

Name of Treating Physician Signature of Treating Physician Date

(Please type or print)

Name of Clinic/Office __________________________Telephone # ______________ Fax # __________

Student Hospitalized: ____________________________Phone ___________Room Number _________

Admission Date ____________ Expected date of discharge from hospital ____________

***COMPLETED FORMS** FAXED TO 559.457.3376 OR EMAILED TO Lisa.Grider@fresnounified.org*