East Side Union High School District

INFORMATION FOR STUDENT HOME/HOSPITAL APPLICATION

Return Home Hospital Application to: Special Services Department at 830 No. Capitol Ave, San Jose, CA 95133

Eligible students are those who are enrolled in ESUHSD and are temporarily (3 weeks or more) hospitalized or undergoing medical and/or psychological treatment, which does not allow them to participate in their regular school program.

PARENT SECTION: *(Please complete this section and ask your doctor to provide complete information in the section below. Partial information will delay consideration for home teaching.)*

Today's Date _____

Student Name	School I.D.#	Date of Birth
Parent/Guardian Name	Home Address	City, State, Zip
Home Telephone	Parent's Wk. Phone	Other: (Cell phone #, etc..)

If you are a Special Ed. Student, please check the box. ☐ **If yes, you will need a change of placement done by the school, before the Home Hospital program can start.**

School Student Attends (circle one): Andrew Hill Evergreen Foothill Independence James Lick Mt.Pleasant Oak Grove Piedmont Hills Santa Teresa Silver Creek W.C. Overfelt Yerba Buena Apollo Genesis Pegasus Phoenix _____

Questions? Contact the Registrar at your child's school or Special Service Department @ 408-347-5173.

PHYSICIAN'S SECTION: (Please provide the information requested in as much detail as possible. For disabilities related to a patient's mental health, this section can be completed by a licensed psychologist, please provide a DSM-IV diagnosis for these cases. If follow-up is necessary, you may be contacted by the district nurse or school psychologist.)

Date: _____

Diagnosis: If Pregnant Expected Due Date: _____

Why is the student unable to attend school?

Indicate here any accommodations which may make school attendance possible on a full-time or part-time bases.

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Date when student may return school: _____ *(Requests for Home Hospital (HH) services must be applied for each school year, there is no automatic carry over from year to year.)*

Date

Home Hospital is **not authorized by a doctor**, but by the East Side Union High School District. The doctor must provide good medical information to East Side Union High School District, Special Services so a valid recommendation can be considered.

_____

Physician's signature

_____

Physician's Name (Please print clearly)

Address _____

City _____ Zip _____

Phone Number ( ) _____ Fax # ( ) _____

Date District Office Received

Home Hospital Application