HOME & HOSPITAL
INFORMATION FOR HEALTH CARE PROVIDERS

Dear Health Care Provider:

Weber School District offers temporary Home and Hospital instruction for students who are deemed too ill to attend school on a regular basis due to a physical or emotional ailment lasting two or more weeks. The intent of the program is short-term assistance until the student is able to resume regular classroom attendance.

As part of the diagnostic statement, please let us know what the student is being treated for, approximately how long this treatment is anticipated, and what medication he/she will be taking. Please address how this illness will affect their ability to attend or participate in school and the length of time you feel is appropriate for them to remain on Home and Hospital.

Program Basics:

- **1-2 hours of direct instruction per week by a licensed educator.**
- Medical Request form must be completed by guardian and health care professional prior to scheduling the Home and Hospital team meeting.
- HIPPA release form must be signed for communication between school nurse and health care provider.
- The Home and Hospital team will determine if a student will be able to participate in extra-curricular activities during the period of Home and Hospital instruction.
- Parent will provide a clean learning environment for instruction and will be present during all teacher visits. Arrangements can be made for instruction at an alternative location such as in a library.
- Student will return to full or part-time school attendance as determined by doctor, parent, and Home & Hospital team.

  Home & Hospital Team consists of school administrator, school nurse, Home & Hospital teacher, school counselor, parent(s), and student (optional)

HOME/HOSPITAL MEDICAL REQUEST

Student____ School ____________________ Grade ________
Last First Initial

Date of Birth ____________Work/Cell Phone: ___________________Home Phone __________________

Male___ Female____ Home Address:____

School contact (nurse): ______________________________ Phone ____________________________

I give my permission for the school nurse to contact my child's health care provider if there are any questions regarding this medical condition.

Parent/Guardian Signature____ Date___________

STATEMENT OF HEALTH PROFESSIONAL

This statement is to be completed by the licensed physician, licensed psychologist, licensed social worker, or licensed health care provider overseeing treatment and verifying the condition requiring the absence from school. The purpose of this placement is to lend temporary educational support to students experiencing health problems. (**Approximately 1-2 hours per week**)

Diagnostic Statement:____

____ Date of exam: __________________

Medications: ____

Recommendation for estimated time student will require Home/Hospital instruction:

BEGINNING DATE: ________________________**ENDING DATE:** ____________________________

Can student attend school part-time? No ____Yes____ If yes, for approximately ______________ hours per day

Name of health professional:____ Phone _______________
Please Print

Address of health professional: ____
Street Address City or Town Zip

Signature of health professional: ____Date:__________

THIS FORM MUST BE COMPLETED & RETURNED TO THE SCHOOL PRIOR TO SCHEDULING A HOME/HOSPITAL MEETING.

(Rev 12/2022)