Section I

Parent/Student Information

To be completed by the parent(s)/guardian(s) prior to completion of Section II by a licensed medical professional.

Name of Student: _____ Date: _____

Address:_____ DOB: _____

School _____ Grade: _____

Full Name of Father/Guardian _____ Work Phone: _____

Full Name of Mother/Guardian _____ Work Phone: _____

Name of Attending Physician:_____ Phone:_____

Address of Physician:_____

Name of Psychiatrist/Psychologist: _____ Phone:_____

Address of Psychiatrist/Psychologist:_____

Reason for Request of Home/Hospital Instruction:_____

_____

Does the student have an Individualized Education Plan (IEP) or 504 Plan: _____ Yes _____No

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RELEASE OF INFORMATION

Release of information from the student's medical provider(s) is necessary in the event additional information is required to approve the application for Home/Hospital Instruction.

I hereby authorize the Home/Hospital Review Committee, to contact, consult with and obtain any further information in relation to this request that they may deem appropriate relating to my child's medical condition and/or treatment, from any medical or mental health care provider and/or pharmacist that has provided medical or health services to my child.

_____ _____

Parent/Guardian Signature Date