

State of Hawaii  
**DEPARTMENT OF EDUCATION**  
 Office of Student Support Services  
 Student Services Branch, School Health Section

**REQUEST FOR HOME HOSPITAL INSTRUCTION SERVICES**

**SECTION I: STUDENT DATA**

**INSTRUCTIONS:**

1. The requester completes "Section I: Student Data" and obtains signature of parent(s)/legal guardian(s).
2. The licensed healthcare provider completes "Section II: Licensed Healthcare Provider'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.**

Student's Name: \_\_\_\_\_  
Last First MI

School: \_\_\_\_\_

Grade: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Student ID#: \_\_\_\_\_

General Education [ ]      Section 504 [ ]      Special Education [ ]      English Learner [ ]

Parent/Legal Guardian Name: _____	Parent/Legal Guardian Name: _____
Cell Phone #: _____	Cell Phone #: _____
Work Phone #: _____	Work Phone #: _____

Emergency Contact  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ 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, licensed healthcare provider completing Section II, and appropriate nursing staff (i.e. Department of Health Public Health Nurse, Hawaii Keiki Nurse).

I **do not** give my consent to release and discuss health information pertinent to my child's condition between the school, licensed healthcare provider completing Section II, and appropriate nursing staff (i.e. Department of Health Public Health Nurse, Hawaii Keiki Nurse).

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip Code

Requested By: \_\_\_\_\_  
Name Relationship to Student

## SECTION II: LICENSED HEALTHCARE PROVIDER'S VERIFICATION

INFORMATION REGARDING THE NATURE OF STUDENT'S MEDICAL/MENTAL HEALTH CONDITION PROVIDED BY THE STUDENT'S LICENSED HEALTHCARE PROVIDER

Student's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Section A

The student named above has a physical and/or mental health condition as follows:

physical health condition: \_\_\_\_\_

mental health condition: \_\_\_\_\_

Does the student have a communicable disease that poses a risk to others?  Yes  No

Based on my examination, the student has a physical and/or mental health condition:

and must remain in home or hospital for a minimum of ten (10) consecutive school days. *(Skip to Section C)*

and is able to attend school for a shortened day and/or with other accommodations. *(Continue to next section)*

but does not require absence from school for ten (10) consecutive school days, a shortened day, or any other accommodations. *(Skip to Section D)*

### Section B

The student named above requires the following accommodations: \_\_\_\_\_

\_\_\_\_\_  
*(Continue to next section)*

### Section C

The student named above is not able to attend school for a minimum of ten (10) consecutive school days. It is anticipated the student will not be able to attend school for \_\_\_\_ weeks, with an expected return date of \_\_\_\_\_. *(Continue to next section)*

### Section D

Healthcare Provider Name:

Healthcare Provider Signature:

Date:

Address:

Phone:

### SECTION III: SCHOOL ACTION

<b>A. TUTORIAL ASSISTANCE TO BE PROVIDED:</b> (NOTE: Additional pages may be attached as needed.)		
<b>Subject Area</b>	<b>Description of Class Assignments, Assessments, and Due Dates</b>	<b>Instructional Materials</b> (School will provide required instructional materials.)

Explain any instructional adjustments necessary:

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**B. SUPPORT SERVICES:**

If general education student, was Section 504 and/or IEP referral completed?    Yes    No

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

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**D. TUTOR:**

- Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- 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/legal guardian, or an adult authorized in writing by the parent/legal guardian, is present for the duration of tutorial sessions. Sessions must be conducted in the home or hospital setting.**

**E. PRINCIPAL/DESIGNEE APPROVAL/DISAPPROVAL:**

Approved, with a return date of: \_\_\_\_\_    Disapproved, because: \_\_\_\_\_.

Principal/Designee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DISTRICT OFFICE ACTION** (for Official Use Only)

Date received: \_\_\_\_\_ Start date: \_\_\_\_\_ Database entry date: \_\_\_\_\_ Distribution: School, District Office, Parent/Legal Guardian