**HUMBOLDT COUNTY OFFICE OF EDUCATION HOME AND HOSPITAL APPLICATION**

*When sections A and B are completed please return to:*
*Damon Collier, Principal, Glen Paul School*
*2501 Cypress Ave*
*Eureka, CA 95503*
*Fax (707) 445-7114*
*dcollier@hcoe.org*

A. Student information (To be completed by Parent)

Name of Student: _____ Date of Birth: _____

Does the student receive special education services (IEP)? ☐ **Yes** ☐ **No**

School of Attendance: _____Grade:_____

Home Address:_____

Parent Name _____Phone: _____

Parent Name:_____Phone: _____

*I hereby apply for home and hospital services for my child and authorize the release of the medical information requested below to Glen Paul School.*

Parent/Guardian name:_____Date: _____

Parent/Guardian Signature: _____

Parent/Guardian name:_____Date: _____

Parent/Guardian Signature: _____

B. Statement by Physician or Psychiatrist/Licensed Psychologist

Students who are unable to attend a regular school program for more than three weeks because of illness are eligible for consideration to the H&H Instructional Program. The above-named student has been referred to our H&H Program. Please provide the following information.

Application based on ☐ Physical Condition ☐ Emotional Condition

Date of Examination: _____

Medical Treatment Plan: **(TO BE COMPLETED BY REFERRING PHYSICIAN, PSYCHIATRIST, or LICENSED PSYCHOLOGIST)**

Please describe (in detail) the physical/emotional condition that is present for this student that will not allow the student to access his/her current education program: _____

_____

_____

_____

Do you certify that the student cannot receive education in a less restrictive environment than his/her home? ☐ Yes ☐ No

How long will the student's condition keep the student out of regular school? _____

Date of anticipated return to school: _____

Is the student seen on regularly scheduled visits to your office? ☐ Yes ☐ No

Is the student currently on medication? ☐ Yes ☐ No

Is the student confined to home or hospital? ☐ Yes ☐ No

Is the student in a communicable or contagious state? ☐ Yes ☐ No

If the condition is emotional, is the student currently in therapy/counseling? ☐ Yes ☐ No

Frequency of visits? _____

What is the transition/treatment plan for this student which will result in their return to his/her regular educational program or setting? _____

_____

_____

_____

What is the anticipated date of return to regular school? _____

*Continuation of service need beyond 60 calendar days requires re-verification of service need.*

Additional comments: _____

_____

_____

Print Name: _____ Signature _____

**Please circle**: *Physician, Psychiatrist, Licensed Psychologist*

Address: _____

Phone: _____