MANHATTAN BEACH UNIFIED SCHOOL DISTRICT

REQUEST FOR HOME OR HOSPITAL INSTRUCTION

Return this form by email to:

Manhattan Beach Unified School District
Student Services – Attention: Charlene Lawrence
Email: clawrence@mbusd.org
325 S. Peck Avenue
Manhattan Beach, California 90266
Telephone: (310) 318-7345, Ext. 5971

STUDENT'S NAME: ____ BIRTHDATE: _______ AGE: ______________
SCHOOL: ______________________________ GRADE: ___________ SPECIAL EDUCATION: ______Yes _____No
PARENT/GUARDIAN: ______________________________________ PHONE: _______________________________
ADDRESS: ____
(Street) (City) (State) (Zip)

Section 1: To be completed by the Parent/Guardian

Parent Signature: ____ *Date*: ________________________________

As the parent or legal guardian of the above named student and by my signature above, I authorize the Manhattan Beach Unified School District and the following physician(s) or agency to release and exchange medical information relative to the above named student. I certify I am aware that I have the right to review any requested records and receive a copy of any materials forwarded.

Section 2: To be completed by the ATTENDING physician

Print Physician's/Name:____

For purposes of home or hospital instruction, a temporary disability consists of a physical, mental or emotional disability, after which the student can reasonably be expected to return to regular day classes or an alternative education program without special intervention.

Temporary Disability: ____
Other Current Diagnoses: ____
Date of Onset of Temporary Disability (mm/dd/yy): ____
*Date Student Stopped Attending School Due to Temporary Disability (mm/dd/yy):*________________________
Date of Expected Return to School [required](mm/dd/yy): ____
Frequency of contact with you _________________ *Treatment Plan (i.e., what is being done to assist the student to return to school?):* ____

- *Adjunct Therapies:* ____
- *Counseling:* ____
- *OT/PT:*____
- *Ongoing diagnostic assessments (i.e. MRI/CT Scan/etc.):* _________________________________
- *Other:* ____

School Attendance:

- *Explain why the temporary disability makes school attendance impossible or inadvisable:* ___________
____
- *Could the student attend school on a modified schedule?* ___ *NO* ___*YES @ Hours/Day:* ____________
- *IF the student were able to attend school on a modified schedule, what* <u>*limitations*</u> *would exist and what* <u>*modifications or accommodations*</u> *would you recommend?* ___________________________________
____

Physician's Signature ______________________ License Number ______________________

Telephone Number Email Address Date

Physician's Office Stamp Here (REQUIRED):