



PASADENA UNIFIED SCHOOL DISTRICT
EDUCATION CENTER • HEALTH PROGRAMS

Our Children. Learning Today. Leading Tomorrow.

MEDICAL REFERRAL FOR HOME HOSPITAL INSTRUCTION

School: Please complete the Student Information: Aeries Student ID#: _____

Form with fields for Name, Address, Phone, Parent/Guardian, and IEP details.

This section to be completed by Parent/ Legal Guardian

PARENT/GUARDIAN AUTHORIZATION TO RECEIVE/RELEASE MEDICAL & ACADEMIC INFORMATION relevant to current treatment plan and planning for safe school environment to Pasadena Unified School District:

Parent Signature: _____ Date: _____

This section to be completed by student's attending Healthcare Provider

Summary description of Diagnosis/Medical Problem, Treatment Plan, and Temporary Disability making school attendance impossible or inadvisable: _____

Is student now hospitalized? Yes [] No [] If yes, where? _____

Anticipated Discharge Date: _____

Is student contagious?.....Yes [] No []

Is student physically capable of attending classes on any school campus now? Yes [] No []

Effective Date AND Estimated date of student resuming attendance on the school campus

Attending Physician Signature: _____ Date: _____

Provider/Agency Name: _____ Phone: () _____

Address: _____ Fax: () _____