

**GRANITE SCHOOL DISTRICT HOMEBOUND-HOSPITALIZED PROGRAM**

**Parent Release and Physician Recommendation**

**To the Parent:**

1. This form should be completed by a physician/medical professional and faxed or mailed to the District Coordinator of the Home Hospital Program at 801-646-4635 , 2500 South State Street, SLC, UT 84115-3110.
2. Your signature authorizes the release to Granite School District (GSD) of medical, psychological and other information regarding your child's diagnosis, limitations, and other data and also authorizes Granite School District to release and discuss information with those providing this type of information to GSD.
3. Additional data may be needed at a future date. GSD will notify you when this need occurs. **A new form** is required at the beginning of each school term.

1. Student's Full Name (please print):	2. Date of Birth:	3. Parent's Name:	4. Phone Number:
5. Street Address:			
I, the undersigned, authorize the release of any and all medical, psychological and other related professional information and reports regarding the above-named student to Granite School District and authorize Granite School District to release and discuss information and reports with those providing medical, psychological and other related information to Granite School District.			
<b>Parent's Signature:</b>			Date:

**To the Attending Physician/Medical Professional:**

1. The Home Hospital Program is reserved exclusively for students who are physically or mentally confined to home or hospital because of illness. When a student is confined to the home because of a mental condition, **documentation of ongoing therapy is required**. The Home Hospital Program is **not** a program to be used **in addition to** regular school. This program is **in place of** regular school, with a student receiving two hours of instruction per week.
2. An updated form is required at the beginning of each school term.
3. Please return this form to the Home Hospital Office on or before \_\_\_\_\_.

**ATTENDING PHYSICIAN'S/MEDICAL PROFESSIONAL'S STATEMENT:**

<b>D I A G N O S I S</b>	Include nature, duration and extent of illness (either medical or psychological):		
<b>T R E A T M E N T</b>	A. Date of First Visit:	B. Date of Last Visit:	C. Frequency of Visits:
	D. Nature of Treatment/Medications:		
	E. Other Mitigating Measures and/or counseling therapy:		
	<b>1-</b>		

S C H O O L  L I M I T A T I O N S	Student's <b>School Activities</b> affected by the above diagnosis. Please indicate nature, duration and extent of limitations(i.e.: confined to the home, hospitalized, contagious, limited physical activity, shortened day, etc):
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<b>FOR REEVALUATION PURPOSES ONLY</b>	
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R E E V A L U A T I O N	<p>A. Patient Has:    <input type="checkbox"/> Recovered            <input type="checkbox"/> Improved            <input type="checkbox"/> Not Changed            <input type="checkbox"/> Retrogressed            <input type="checkbox"/> Other</p> <p>Explain</p> <p>B. Prognosis for Future:</p>
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O T H E R	A. Additional significant information/data:
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B. The District Coordinator of the Home Hospital Program and/or other Granite School District professionals may contact you in order to speak with you regarding this report.

S I G N A T U R E	Name of Attending Physician/Medical Professional (please print):	Degree:	Phone Number:
Street Address:			
Signature:		Date:	