**REQUEST FOR**
**HOME/HOSPITAL INSTRUCTION**
**SPOKANE PUBLIC SCHOOLS**

Spokane Public Schools
*excellence for everyone*

STUDENT NAME: _____ GRADE: _____

☐ MALE ☐ FEMALE

School Student Attends: _____
City and State: _____

**HEALTH SERVICES CONTACT: Christal Raver, Phone #: (509) 354-7329 FAX #: (509) 354-5910**

***SECTION 1: THIS SECTION TO BE COMPLETED BY A QUALIFIED MEDICAL PRACTITIONER***

***DIAGNOSIS:***

☐ DISEASE/INJURY (Specify Primary Diagnosis) _____
_____

☐ DRUG/ALCOHOL TREATMENT
_____

☐ PREGNANCY
Medical Reason for Absence_____
Due Date/Delivery Date _____

☐ OTHER (Please Specify)_____

_____

**I CERTIFY THAT THIS STUDENT IS UNABLE TO ATTEND PUBLIC SCHOOL FOR _____ WEEKS. Must be a minimum of 4 weeks.**

| *PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER* | *BUSINESS ADDRESS:* |
|---|---|
| _____Phone #: _____<br>(Print)<br><br>_____<br>(Signature) (Date) | |

***SECTION 2: THIS SECTION FOR SCHOOL DISTRICT USE***

| Please check one: | Beginning date of services: _____<br>End date of services: _____ |
|---|---|
| ___X___ ORIGINAL REQUEST | If the student is eligible to receive special education services, does the IEP team need to meet? _____ Yes _____ No _____ Other |
| _____ EXTENSION | _____ |

**Please return form to: Christal Raver, Spokane Public Schools, 200 N. Bernard, Spokane, WA 99201. Form may be faxed to 354-5910. Questions? Please call 354-7329.**

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# AUTHORIZATION FOR RELEASE OF HEALTH CARE AND/OR EDUCATION INFORMATION

**Student #**: _____
**Student's Name**: _____ **Birthdate**: _____
**Date**: _____ **School**: _____

I authorize the release of the information described below to be released FROM and sent TO the following:

**Information to be released FROM**:

_____
*Name of facility/agency/provider*

_____
*Address*

_____
*City, State, Zip Code*

_____
*Phone* *FAX*

**Information to be released TO:**

**Spokane Public Schools**
Rebecca Doughty, Director, Health Services
Christal Raver, Specialist, Student Services

**Christal Raver**, email: christalr@spokaneschools.org
200 North Bernard, Spokane, WA 99201
PHONE: (509) 354-7329 FAX: (509) 354-5910

☐ School Psychologist_____
☐ School Counselor _____
☐ School Lead Nurse _____
☐ Other _____

**Specific information to be released:** Medical diagnosis and number of weeks it is anticipated the student will be out of school.
**Purpose for which disclosure is being made**: To determine Home Hospital Teaching program qualification.

**Specific Minor Patient Authorization**
*If the student is a minor but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form (RCW 70.02.030).
__ HIV/AIDS, STD's status, diagnosis, treatment (consent may be given by student 14 years of age)
__ Family planning/abortion (consent may be given by any age student)
__ Alcohol/drug treatment (consent may be given by student 13 years of age)
__ Mental health services (consent may be given by student 13 years of age)

**My Rights** I understand the following:
I have a right to request and receive a Notice of Privacy Practices from the above named provider. I may inspect and receive a copy (a nominal fee may be charged). I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party. I can revoke this authorization at any time in writing but the revocation will not apply to information already used or disclosed. I recognize that this information, once received by the school district, may no longer be protected by the HIPAA Privacy Rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedure. The provider must make the health care information available within 15 working days after receiving the request or notify the patient of any delay (RCW 70.02.080).

***This Authorization expires with the end of the school year or on ____/____/____, whichever is sooner.***

_____ Date: _____
Signature of patient/legal representative (or student* if appropriate)

_____ _____ _____
Relationship to patient Phone Number Student's Signature