Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

REQUEST FOR CONSIDERATION OF ENROLLMENT IN THE HOMEBOUND/HOSPITALIZED INSTRUCTIONAL PROGRAM
SOLICITUD PARA CONSIDERAR INSCRIPCIÓN EN EL PROGRAMA DE INSTRUCCIÓN PARA ESTUDIANTES EN EL HOGAR U HOSPITAL
DEMAND POU KONSIDERE ENSKRIPSYON NAN PWOGRAM ENSTRIKSYON POU MOUN MALAD KI RETE LAKAY/OSPITALIZE

Mail or Fax completed forms to:
Llene el formulario y envielo por correo o facsímile a:
Ranpli fòm yo epi Poste oubyen fask yo ba:
Brucie Ball Educational Center
11001 SW 76 Street
Miami, Florida 33173
Telephone: (305) 514-5100
Fax: (305) 447-3761

To be considered for services from the Homebound/Hospitalized program, it is necessary that the referring physician and/or psychiatrist make a recommendation. The parent or legal guardian must sign below, releasing information from the physician/psychiatrist to the Miami-Dade County Public Schools Homebound/Hospitalized Instructional Program. The student will not be considered for the Homebound/Hospitalized Instructional Program without this signed release. **Incomplete forms will be returned.**

Es necesario que el médico y / o siquiatra del estudiante haga su recomendación para que pueda ser considerado para los servicios del programa de instrucción para estudiantes en el Hogar u Hospital. El padre, la madre o tutor legal debe firmar abajo, autorizando al médico y / o siquiatra a proveer información al Programa de Instrucción para Estudiantes en el Hogar u Hospital que ofrecen las Escuelas Públicas del Condado Miami-Dade. El estudiante no será considerado para el Programa de Instrucción para Estudiantes en el Hogar u Hospital sin que este formulario haya sido firmado. **Los formularios incompletos serán devueltos.**

Pou nou konsidere w pou resevwa sèvis nan pwogram pou Moun Malad ki Rete Lakay/Ospitalize, li nesesè pou doktè ak/ousnon sikyat la ba w yon rekòmandasyon. Paran an ousnon responsab legal la dwe siyen anba, pou ba doktè/sikyat la otorizasyon pou ba pwogram pou Moun Malad ki Rete Lakay/Ospitalize nan Lekòl Leta Miami-Dade County aksè ak enfòmasyon sa yo. Nou pap konsidere elèv la pou enstriksyon nan pwogram pou Moun Malad ki Rete Lakay/Ospitalize si fòm sa a pa siyen. **Nap retounen fòm ki pa fin ranpli.**

SECTION I - COMPLETED BY THE PARENT/LEGAL GUARDIAN

STUDENT NAME (last, first, middle)	STUDENT NUMBER	BIRTH DATE

ADDRESS (street number & name, apt. no., city, state, zip code)

PARENT NAME (last, first, middle)	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

SCHOOL	GRADE

I hereby authorize the physician to release all information concerning diagnosis, treatment and any medical implications for instruction to the Miami-Dade County Public Schools. This communication may be written or verbal. This release will remain in effect until the student has been dismissed from the Homebound/Hospitalized Instructional Program.

Por la presente autorizo al médico que proporcione a las Escuelas Públicas del Condado Miami-Dade, toda información con relación al diagnóstico, tratamiento y cualquier implicación médica con respecto a la instrucción del estudiante. Esta comunicación puede ser por escrito o verbal. Esta autorización permanecerá en vigor hasta que el estudiante sea retirado del Programa de Instrucción para Estudiantes en el Hogar u Hospital.

Mwen ba otorizasyon m pou doktè ba tout enfòmasyon konsènan dyagnostik, tretman ak nenpòt kondisyon medikal ba Lekòl Leta Miami-Dade County. Kominikasyon sa a ka pa ekri ousnon vèbal. Otorizasyon sa a pral rete valid jiska ke elèv la kite pwogram pou Moun Malad ki Rete Lakay/Ospitalize.

Must be signed by parent/legal guardian **or** _____ _____
student at the age of majority (18 years or older) DATE

Debe ser firmado por el padre, la madre o tutor legal **o** _____ _____
el estudiante si es mayor de edad (18 años o mayor) FECHA

Paran/responsab legal dwe siyen **osnon** _____ _____
elèv ki gen laj majè (18 an ousnon pi gran) DAT

SECTION II - COMPLETED BY THE PHYSICIAN/PSYCHIATRIST

PHYSICIAN/PSYCHIATRIST NAME	PHYSICIAN/PSYCHIATRIST SPECIALTY	TELEPHONE NUMBER

PHYSICIAN/PSYCHIATRIST ADDRESS

EXPECTED DATE OF RETURN: An anticipated date of return to school must be determined by the physician. If an undetermined date is indicated, the form will be returned to the physician and/or psychiatrist for an expected date of return. Returned forms will delay the consideration of a student's possible placement into the Homebound/Hospitalized Instructional Program. If, during treatment, the physician/psychiatrist needs to extend the expected date of return to school, the physician/psychiatrist may do so by submitting a new form which reflects the revised date of return. If the student can return to school prior to the expected date written below, a Physician's Release of Student Form will be required. The amended form or letter can be faxed to the Homebound/Hospitalized Instructional Program office, FAX number (305) 447-3761.

EXPECTED SCHOOL RETURN DATE (MANDATORY) _____ **(mm/dd/yy)**

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STUDENT NAME (last, first, middle)	STUDENT NUMBER

Medical or psychiatrist diagnosis (attach additional sheets if necessary) **(please print)**

ELIGIBILITY: The licensed physician must certify that the student meets **all** of the following criteria for eligibility. Students who do not meet all of the minimum eligibility criteria listed below will not be eligible for the Homebound/Hospitalized Instructional Program. **All questions must be answered "yes" and initialed by the physician in order to certify eligibility.**

YES	NO	INITIAL	
☐	☐	_____	1. Is the student expected to be absent from school due to a physical or psychiatric condition for at least fifteen (15) consecutive school days or the equivalent on a block schedule?
☐	☐	_____	2. Is the student **confined** to the home or hospital?
☐	☐	_____	3. Will the student be able to participate in and benefit from an instructional program?
☐	☐	_____	4. Is the student under medical care for illness or injury which is acute, catastrophic, or chronic in nature?
☐	☐	_____	5. Can the student receive instructional services without endangering the health and safety of the instructor or other students the instructor may come in contact?

Students entering the Homebound/Hospitalized Instructional Program will be placed in the most restrictive educational and social environment where the student will not have physical contact with their peers during the school day.

YES	NO	INITIAL	
☐	☐	_____	6. Do you recommend the student be placed in this most restrictive environment?

THE STUDENT REQUIRES (CHECK ONE)**:**

- ☐ Continuous placement in the Homebound/Hospitalized Instructional Program
- ☐ Intermittent placement in the Homebound/Hospitalized Instructional Program
- ☐ Partial day at school _____ hours _____ days

TREATMENT PLAN AND OTHER INFORMATION (CHECK ALL THAT APPLY):

- ☐ Medication Management
- ☐ Surgical Management
- ☐ Post-surgical recovery
- ☐ Psychotherapy
- ☐ Chemotherapy
- ☐ Dialysis
- ☐ Frequent medical monitoring and follow up
- ☐ Hospitalization
- ☐ Bed rest
- ☐ Other _____
- ☐ Return to school will require _____

_____ _____
SIGNATURE OF PHYSICIAN DATE

Signature must be an original signature.
Reproductions such as a stamp will not be accepted.

Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION

Date _____

Student's Name _____

Date of Birth _____ ID# _____

I hereby authorize the mutual exchange of records pertaining to my child or myself, _____ _____, between the MIAMI-DADE COUNTY PUBLIC SCHOOLS and the following agencies (include all schools, physicians, psychologists, hospitals, clinics, etc., that have had significant contact with your child):

Name	**Address**

- The specific records to be disclosed pertain to: _____
- The purpose for making these records available is: _____
- **The receiving party will not disclose the information to any other party without signed consent.**

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

_____ _____
Name (print) Signature

_____ _____ _____
Address City, State Zip Code

Please return this form to: _____

ESCUELAS PÚBLICAS DEL CONDADO MIAMI-DADE

CARTA DE CONSENTIMIENTO PARA EL INTERCAMBIO MUTUO DE INFORMACIÓN (CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION)

Fecha _____

Nombre del estudiante _____

Fecha de nacimiento _____ Número de identidad _____

Con la presente carta autorizo el intercambio de información en referencia a mi hijo o mi persona, _____, entre las Escuelas Públicas del Condado de Miami-Dade (MIAMI-DADE COUNTY PUBLIC SCHOOLS) y las siguientes agencias (incluyendo escuelas, médicos, sicólogos, hospitales, clínicas, etc., que han tenido que ver con su hijo/hija):

Nombre	**Dirección**

- Los documentos específicos divulgados conciernen: _____

_____

- La razón de tener estos documentos disponibles es: _____

_____

- **La(s) persona(s) que reciba(n) estos documentos no divulgará(n) la información con otras personas y/o agencias sin su consentimiento.**

Hago constar que soy el padre o tutor legal del niño cuyo nombre se menciona arriba o que soy un estudiante mayor de edad y estoy autorizado para firmar esta carta de autorización.

_____ _____
Nombre Firma

_____ _____ _____
Dirección Ciudad, Estado Código postal

Sírvase devolver esta carta a: _____

_____

_____

_____

Miami-Dade County Public Schools
giving our students the world

LEKÒL PIBLIK MIYAMI

FŃM KONSANTMEN POU ECHANJ EMFŃMASYON
(CONSENT FORM FOR MUTUAL EXCHANGE OF INFORMATION)

Dat _____

Nom elèv _____

Dat li fèt _____ ID# _____

Mwen otorize ke yo fe echanj enfomasyon sou dosye pitit mwen ou dosye pa-m, _____ , ant Lekòl Leta Miami-Dade Konti ak ajns sa yo mete (tout lekòl, doktè, sikològ, klinik, esetera, ki te an afè avèk pitit ou):

Nom	**Adrès**

- Dosye yo kapab kite moun wè yo, se dosye ki gen rapò ak: _____

- Dosye yo kapab kite moun wè yo, se dosye ki gen rapò ak: _____

- **Moun ki resevwa dosye ya p'ap kite okenn lot moun wè yo san yon konsantman siyen.**

Mwen sètifye ke se mwen ki paran ou gadyen timoun, non ekri anro,fòm sa a ou swa mwen se yon elèv ki majè e ke mwen gen otorite ou siyen pèmisyon sa a.

_____ _____
Non Siyati

_____
Adrès

Sil vou plè, retounen fòm sa bay: _____