DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of Specialized Instruction

Home and Hospital instruction Program

PROOF OF IMMUNIZATION FORM

THIS FORM MUST BE SUBMITTED WITH A COPY OF THE STUDENT'S
PROOF OF IMMUNIZATION DOCUMENTATION

To be completed by School's HIP Designee and School Nurse

STUDENT:_____DATE OF BIRTH:_____

STUDENT ID NO._____ GRADE:_____SCHOOL:_____

This form is submitted to the Home/Hospital Instruction Program, along with appropriate documentation supporting proof of immunization for _____.
(Student)

Submittal of this form also verifies that the student is in compliance with the District of Columbia Public Schools (DCPS) Immunization Policy for SY 2012-2013.

School's HIP Designee's Signature:_____

School's HIP Designee's Title:_____**Date:**_____

School Nurse's Signature: _____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of Teaching and Learning

Home/Hospital Instruction Program (HHIP)

SCHOOL REQUEST FOR SERVICE

Directions: Type or print information in ink. This form must be completed in its entirety. A Home and Hospital Instruction Program (HHIP) referral is not complete until all of the following documents have been received:

- Request for Service form
- Physician Verification form
- Immunization form
- Parent/Guardian Agreement form
- IEP or 504 Plan (if applicable)

Student Profile (please print)

Name: _____ Age: _____

Date of Birth: _____ Male: ___ Female: ___ Student ID: _____

School: _____ Grade: _____

Counselor: _____ Phone: _____

Counselor's Email: _____

HHIP Designee: _____ Phone: _____

HHIP Designee's Email: _____

Home Address: _____

Parent/Guardian: _____

Parent's Email: _____

Home Phone: _____ Cell Phone: _____

DISTRICT OF COLUMBIA
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Office of Teaching and Learning

Home/Hospital Instruction Program (HHIP)

Additional Information:

Reason for Referral: _____

_____

Special Information/Comments: _____

_____

IEP: _____ 504 Plan: _____

NOTE: Signatures Required Before Submitting Application

By signing below, we acknowledge that we are forming a partnership with the Home and Hospital Instruction Program (HHIP) staff in order to facilitate and support the delivery of educational services. THE PUBLIC SCHOOL WHERE THE STUDENT IS ENROLLED WILL:

- Upload all assignments and assessments in OneNote;
- Provide all instructional resources to the student during his/her enrollment in HHIP (e.g. textbooks);
- Continue all IEP and 504 process(es), if applicable;
- Maintain communication with the HHIP coordinator;

_____ Date: _____
HHIP Designee's Signature

_____ Date: _____
Principal's Signature

UPLOAD ALL FORMS TO THE HHIP QUICKBASE APP

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
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PHYSICIAN VERIFICATION FORM

(**NOTE**: Provision of incomplete information below may delay application process)

PART I: To be completed by the school's HHIP Designee

Name: _____ DOB: _____ Telephone: _____

School: _____ Grade: _____

Date Parent Received Form: _____ Date Designee Received Form: _____

School Staff Who Received Form: _____

PART II: Treating Physician's Treatment Plan

The treating physician for the diagnosis listed below should complete the following section. We will be contacting the physician with follow-up questions to help us determine the student's eligibility to receive HHIP services.

1. Please indicate the student's diagnosis:

2. How will the physical and/or psychiatric condition you have diagnosed significantly limit the student's ability to receive educational benefits in the regular school setting? In what way(s) would the student's ability to function in the school setting be impacted? Why is the student confined to the home or hospital?

3. Describe your treatment plan for the student. What is the frequency and duration of the treatment?

4. List any medication(s) the student is taking and explain the effects, if any, that the mediation(s) may have on the student's ability to achieve educational benefit in the school setting.

5. **Psychological/Mental Health Cases ONLY**

   Name of treatment program: _____

   Intensive Day Treatment Program?

   Start Date & Start Time: _____ End Date & End Time: _____

   Partial-hospitalization?

   Days: _____ Start Time: _____ End Time: _____

6. **Pregnancy ONLY** – Please provide the Expected Delivery Date: _____

   Is the student on bed rest at this time? **YES** **NO**

   HHIP will provide instruction for 6 weeks (regular) or 8 weeks (cesarean) after delivery. (*Note: Maternity leave and HHIP services begin on the delivery date.*)

7. Recommended date to begin HHIP: _____

   Recommended date student is to return to school: _____

Physician's Certification: I certify that this student is under my care and treatment for the aforementioned illness. My recommendation has been made on the medical needs of the patient.

This certifies that this treatment plan is medically necessary. It MUST be completed by the treating physician or psychiatrist.

Continuation of service beyond 60 calendar days, including emotional conditions requires written re-verification and a medical review. A new Physician Verification Form must be submitted to the HHIP Office prior to the expiration of the 60 calendar days.

_____	_____	_____
(Print) Physician's Name	Physician's Signature	Date

License #: _____

Hospital/Clinic: _____

Phone Number: _____

Email Address: _____

Physician should fax completed forms to 202-654-6020

PRIVACY: In accordance with the Family Educational rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) DCPS ensures that education records, including health records, are not released to third parties outside of emergency circumstances or consent from the parent/guardian. This form will only be accessed by staff either directly involved in deciding about a student's placement or directly involved in administering education services to the student. This form may be shared with school nurses, physicians, and health care providers for treatment purposes only. If there is an emergency threatening the student's safety this information may only be shared with individuals whose knowledge of these records will assist in protecting the student or others from the threat.