Springs CHARTER SCHOOLS
HEALTH SERVICES DEPARTMENT

Extenuating Circumstances Referral

An extenuating circumstance can be a health condition that requires short-term modifications to serve students who incur a **temporary disability**, impacting regular school attendance and progress. A temporary disability is defined as a physical or mental health disability such as a communicable disease, a broken limb significantly impacting mobility, childbirth complications or temporary emotional impact due to the death of a loved one. In these situations, adjustments to the current education program can be offered. If a family/student requires in-person in-home/in-hospital services, the student will need to be referred to the district in which they reside or are currently receiving treatment, as Springs Charter Schools does not provide home and hospital instruction (HHI).

*Although Springs Charter Schools does not provide HHI, support to parents and students will be provided to transition the student to the appropriate district for services. The student's current enrollment in a Springs Charter program will be held for them and re-enrollment in the same program is guaranteed upon return from a HHI enrollment.

Terms

A **"temporary disability"** does not include chronic conditions or a disability for which a student is identified as an individual with exceptional needs pursuant to California *Education Code* (*EC*) Section 56026.

Student Name: _____ DOB: _____ Grade: _____

School Site: _____

Address: _____ City: _____ Zip_____

Parent/Guardian: _____ Parent/Guardian Email: _____

Does your student have a current IEP? [ ] Yes [ ] No
If yes, the SPED department needs to be notified to provide accommodations.

Section 504 Plan? [ ] Yes [ ] No Condition related to 504 Plan _____

By signing this authorization for service, the parent/guardian agrees to the following: Please initial each section.

A physician's note is not an authorization, but a referral so that accommodations can be addressed and valid placement may be considered. **Chronic conditions** may not qualify. _____

Temporary school site accommodations and/or alternative educational adjustments such as independent/home study, adjustment of school day/progress expectation, or other modified instruction are the only alternatives provided by Springs Charter Schools at this time. _____

AS THE PARENT OR LEGAL GUARDIAN OF THE ABOVE-NAMED STUDENT, MY SIGNATURE BELOW PROVIDES AUTHORIZATION TO SPRINGS CHARTER, THE TREATING PHYSICIAN AND/OR LICENSED PSYCHOLOGIST TO RELEASE/EXCHANGE MEDICAL AND ACADEMIC INFORMATION OF THE ABOVE-NAMED STUDENT TO DETERMINE ELIGIBILITY, SERVICES AND TEMPORARY TRANSFER.

Parent Name (Print): _____ Date: _____

Parent Signature: _____ Date: _____

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This form is valid for the current school year only: _____ - _____

PHYSICIAN: A request for temporary educational program adjustments is being made for the above-named student. Springs Charter Schools requires that a licensed California **physician, psychiatrist, or licensed clinical psychologist,** currently treating the student, file a statement that includes a medical diagnosis to the extent that the student is unable to attend classes on any school campus. **Chronic conditions** may not qualify.

Attending Physician's Statement

Is the student physically capable of attending classes on his/her school campus now, with accommodations to meet his/her physical or other needs? [ ] YES [ ] NO

If yes, please list accommodations: _____

_____

Would the student's condition allow for participation in an educational alternative activity meeting individually with a teacher at a school site? [ ] YES [ ] NO **(If yes:** ☐ 1-2 hrs/day ☐ 2-3 hrs/day ☐ 3-4 hrs/day)

Can the student participate in virtual instruction? [ ] YES [ ] NO

If no, please explain: _____

_____

Diagnosis (with ICD code): _____

_____

Summary of therapeutic plan to enable the student to return to school: _____

_____

_____

I estimate this student will be homebound until (specific date required): _____

Currently in treatment/therapy? [ ] YES [ ] NO (If yes, start date: _____ How often? _____

Is the student a danger to self or others: [ ] YES [ ] NO if yes, explain: _____

*My signature indicates that I certify this student is a candidate for short-term modifications/services because of a **temporary** disability. I understand that a chronic condition may not qualify.

Physician or Psychiatrist Name (printed): _____ License Number: _____

Physician or Psychiatrist Signature: _____ Date: _____

Hospital/Office Address: _____

Phone Number: _____ Fax: _____ Email: _____

Return Fax: 951-489-0494 or email: school.nurse@springscs.org