



REQUEST FOR HOME/HOSPITAL INSTRUCTION

School District Name Issaquah School District		Student Name (Last, First, Middle Initial) Please Print	
Contact Person Barb Johnson	Telephone Number 425-837-7085	Student Grade Level	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

SECTION 1 – THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

DIAGNOSIS:

- Disease/Injury/Surgery (primary diagnosis): _____
- _____
- Drug/Alcohol Treatment
- Pregnancy
- Other (describe): _____

I certify that this student is unable to attend public school for _____ weeks.

_____ TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER	BUSINESS ADDRESS
_____ SIGNATURE DATE	CONTACT PHONE NUMBER

SECTION 2 – THIS SECTION FOR SCHOOL DISTRICT USE

If the student is eligible to receive special education services, does the IEP team need to meet? Yes No

Original Request Beginning date of instructional time or extension: _____

Mo/Day/Year

Extension NOTE: Beginning date on extension request must consecutively follow ending date of original

 SCHOOL DISTRICT AUTHORIZATION DATE