REQUEST FOR
HOME/HOSPITAL INSTRUCTION

School District Name
Issaquah School District

Student Name (Last, First, Middle Initial)
Please Print

Contact Person
Karin Farrar
Telephone Number
425-837-7085

Student Grade Level
Gender
- Male
- 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

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: __________________________

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

SCHOOL DISTRICT AUTHORIZATION
DATE

Issaquah, Washington
Last revised: 08/18