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): ______________________________

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☐ 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

____
SIGNATURE DATE

BUSINESS ADDRESS

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