

REQUEST FOR HOME/HOSPITAL INSTRUCTION

STUDENT NAME: (Last, First, Middle) Please Print		SCHOOL DISTRICT NAME: Shoreline School District #121-17-412 18560 1st Ave NE, Shoreline, WA 98155	
SCHOOL:		SCHOOL NURSE:	
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female	STUDENT GRADE LEVEL:	SCHOOL NURSE PHONE:	SCHOOL NURSE FAX:
Is the student eligible to receive special education services?		No <input type="checkbox"/> Yes <input type="checkbox"/>	
If yes, do you wish to participate in the IEP meeting to determine the service plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date IEP team met _____			

SECTION 1 - THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER*

DIAGNOSIS (check one):

Disease/Injury/Surgery: _____
(primary diagnosis)

Drug/Alcohol Treatment _____

Pregnancy _____

Other (describe): _____

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

Doctor's recommendation for the amount of time per day allowed for school work, including instruction is:

_____ PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER*	_____ CONTACT PHONE NUMBER
_____ SIGNATURE OF QUALIFIED MEDICAL PRACTITIONER*	_____ DATE

BUSINESS ADDRESS:

* M.D., D.O., D.M.D., D.C., N.D., P.A., A.R.N.P., certified nurse midwife, or licensed mental health therapist.

SECTION 2 - THIS SECTION FOR SCHOOL DISTRICT USE

_____ FORM REVIEWED FOR COMPLETION, SIGNATURE OF SCHOOL NURSE	_____ DATE
Attention school nurse - please send one copy to District - Student Services, retain one copy for attending school file.	

CHECK ONE:

<input type="checkbox"/> New Request	Beginning date of instructional time:	_____ START DATE
<input type="checkbox"/> Extension	NOTE: Beginning date of extension request must consecutively follow ending date of original request.	_____ START DATE

_____ SCHOOL DISTRICT AUTHORIZATION	_____ DATE
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