STUDENT SERVICES HOME/HOSPITAL INFORMATION FORM

Student Name: _____ Birthdate: _____
LAST FIRST MIDDLE

School: _____ Grade: _____

CONTACT INFORMATION

Address: _____ City & Zip: _____

Please note specific instructions for finding your home (make a map, if necessary, on back of form):

Home Telephone: _____ Email: _____

Guardian 1 Name: _____ Telephone: _____ Relationship to student: _____

Guardian 2 Name: _____ Telephone: _____ Relationship to student: _____

HOME/HOSPITAL INFORMATION

Nature of Condition: _____

Attending Qualified Medical Practitioner*: _____

Qualified Medical Practitioner Telephone: _____

Is the child hospitalized?: _____ If yes, where?: _____

Home/Hospital instruction is provided by the district to students who are temporarily unable to attend school for an estimated period of four (4) weeks or more because of a physical and/or mental disability or illness. Home/Hospital services are limited to a maximum of 18 weeks. The program does not provide tutoring for students caring for an infant or a relative who is ill. Tutoring is not provided during school vacations unless students are enrolled in a district summer school program. Home/Hospital tutoring cannot begin for a student if less than four (4) weeks of school remain in the school year.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

PLEASE RETURN FORM TO:
School Nurse

* 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.

Av 9/1/17