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: ☐ Male ☐ Female	STUDENT GRADE LEVEL:	SCHOOL NURSE PHONE:	SCHOOL NURSE FAX:
Is the student eligible to receive special education services?		No ☐ Yes ☐	

If yes, do you wish to participate in the IEP meeting to determine the service plan? Yes ☐ No ☐

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:

☐ New Request Beginning date of instructional time: _____
START DATE

☐ Extension NOTE: Beginning date of extension request must consecutively follow ending date of original request. _____
START DATE

_____ _____
SCHOOL DISTRICT AUTHORIZATION DATE

Av 9/1/17