Attachment 2

**REQUEST FOR**

**HOME/HOSPITAL (H/H) SERVICES**

**2019-2020 School Year**

SCHOOL DISTRICT NAME

CONTACT PERSON

TELEPHONE NUMBER

STUDENT NAME: (Last, First, Middle) Please Print

STUDENT GRADE LEVEL

GENDER

Female

Male

If the student is eligible to receive special education services, does the IEP team need to meet?

**DIAGNOSIS:**

Disease/Injury/Surgery (primary diagnosis):

Pregnancy

Other\* (describe):

I certify that this student is unable to attend public school for \_\_\_\_\_\_\_ weeks.

Drug/Alcohol Treatment

TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER

SIGNATURE

DATE

CONTACT TELEPHONE NUMBER

BUSINESS ADDRESS

CHECK ONE

Original Request

Extension

NOTE:

Beginning date on extension request must consecutively follow ending date of original.

**SECTION 2—THIS SECTION FOR SCHOOL DISTRICT USE**

Yes

No

Beginning date of instructional time or extension:

MO

DAY

YEAR

SCHOOL DISTRICT AUTHORIZATION

DATE

CONTACT TELEPHONE NUMBER

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