Attachment

REQUEST FOR
HOME/HOSPITAL (H/H) SERVICES
2021-2022 School Year

SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle) Please Print	
CONTACT PERSON	TELEPHONE NUMBER	STUDENT GRADE LEVEL	GENDER ☐ Male ☐ Female

SECTION 1 THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

DIAGNOSIS:

☐ Disease/Injury/Surgery (primary diagnosis): _____

☐ 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

BUSINESS ADDRESS

SIGNATURE DATE

CONTACT TELEPHONE 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

CHECK ONE
☐ Original Request
☐ Extension

Beginning date of instructional time or extension: MO DAY YEAR

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

SCHOOL DISTRICT AUTHORIZATION DATE CONTACT TELEPHONE NUMBER