MOORPARK UNIFIED SCHOOL DISTRICT
INSTRUCTIONAL SERVICES

REQUEST FOR HOME TEACHER (C.E.C. 48206.3)
TO BE COMPLETED BY PARENT/GUARDIAN

Distribution:
☐ Home Teaching Coordinator
☐ School Counselor

Date: ______________________________________

To: Dr. Jane Wagmeister - District Office

I am requesting a home teacher for my child who will be absent from school for at least four weeks due to a temporary disability. I understand that home teaching is limited to five hour per week and is intended to keep my child from falling behind during this time. I understand that I will be working in partnership with the home teacher(s) to make sure assignments are completed to the best of my child's ability. I understand that any alteration of this form may void this request for service.

I hereby authorize my physician to communicate in writing or verbally with the school nurse or counselor regarding the reason for the home teaching request. I also authorize the release to Moorpark Unified School District of my child's medical information that relates to this request. I understand that only the appropriate school professional(s) working with my son/daughter will use the information. This release of information will remain valid during the period of home teaching. I understand that a physician's authorization is required for each semester my child is receiving these services and that an adult will be present for the duration of each teaching session. Incomplete information may delay processing.

____
(Name of Physician)

____
(Physician Address) (City) (State) (Zip)

____
(Physician Office Telephone #)

____
(Student current school and grade)

____
(Student Name) (Date of Birth)

____
(Student home address) (City) (State) (Zip)

____
(Parent/Guardian Printed Name)

____
(Parent/Guardian Signature) (Date)

TO BE COMPLETED BY ATTENDING PHYSICIAN.

I certify that this child is under my care and has a condition that requires an absence of approximately 20 school days or longer. I authorize home teaching and understand this service is limited to five hours of instruction per week. Please provide a brief, non-technical description below.

RATIONALE	PHYSICIAN STATEMENT
Diagnosis: (Indicate temporary disability)	
Prognosis:	
Instruction at home, one hour per school day, to **begin (Specific Date):**	
Instruction at home should be carried out **until (Specific Date):**	
Does this assignment expose the teacher to any contagious condition that can be transmitted by casual contact?	
Comments:	

Signed______________________________ Please Print______________________________
(Attending Physician) (Attending Physician)

Physician: Please return to District Office, Moorpark Unified School District, 5297 Maureen Lane, Moorpark, California 93021, (805) 378-6300, **FAX (805) 531-6641**

☐ I hereby request medical records on this student. Please send to: ______________________________
(Name/Title)

____
(Address)

____
(Signature of School Employee)

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