ISSAQUAH
SCHOOL DISTRICT 411

REQUEST FOR HOME/HOSPITAL SUPPORT

School District Name		Student Name (Last, First , Middle Initial) Please Print	
Issaquah School District			
Contact Person	Telephone Number	Student Grade Level	Student's School
Stacey Slyke	425-837-7157		

SECTION 1 – THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

DIAGNOSIS:

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

_____

☐ Drug/Alcohol Treatment ☐ Pregnancy

☐ Other (describe): _____

☐ Treatment plan included.
*Treatment plan must address student's transition/return to full time participation in their education.

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

_____
TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER

_____
SIGNATURE DATE

BUSINESS ADDRESS

CONTACT PHONE NUMBER

SECTION 2 – THIS SECTION FOR SCHOOL DISTRICT USE

If the student has 504 or IEP, does the team need to meet? ☐ Yes ☐ No

☐ Original request Beginning date of instructional time or extension: _____
Mo/Day/Year

☐ Extension NOTE: Beginning date on extension request must consecutively follow ending date of original request.
Request for extension of Home/Hospital support must include updated treatment plan.

☐ Updated treatment/transition plan included

_____
SCHOOL DISTRICT AUTHORIZATION DATE