SOUTH KITSAP
SCHOOL DISTRICT
Nurturing Growth • Inspiring Achievement • Building Community

MEDICAL REQUEST FOR HOME HOSPITAL INSTRUCTIONS PLEASE RETURN BY EMAIL TO:

South Kitsap School District
Attn: Paul Hulbert hulbert@skschools.org

Student Name: ______________________________ Date: __________

School: ______________ Gender: M ___ F ___ Grade: _____ DOB: __________

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

DIAGNOSIS:

Disease-Injury-Surgery Primary Diagnosis: ______________________________
____

Drug or Alcohol Treatment, Pregnancy, Other (please describe): ______________________________
____

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

Print name of qualified medical practitioner: ______________________________
Business address: ______________________________ Phone Number: __________

Signature: ______________________________ Date: __________

SECTION 2 – THIS SECTION FOR SCHOOL DISTRICT USE

If the student is eligible to receive special education service, does the IEP team need to meet?
Yes ___ No ___

Original Request ☐ Extension ☐ Beginning date of instructional time or extension*: __________

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

School District Authorization: ______________________________ **Date:** __________

Contact Phone Number: ____________________ **Email:** ____________________