



Request for Home/Hospital Instruction

Health Services Walla Walla Public Schools 614 S. 3 rd Ave. Walla Walla, WA 99362		CHECK ONE: ☐ Original Request ☐ Extension NOTE: Beginning date on extension requested must consecutively follow the ending date of original request.	
STUDENT INFORMATION			
Student Name: (last, first, middle initial) PLEASE PRINT		School Where Student is Enrolled	Grade Level:
Student's Parents/Guardian's Name:	Telephone Number:	Enrolled in Special Education? ☐ Yes ☐ No	Gender?
SECTION 1 - TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER			
DIAGNOSIS: ☐ Disease/Injury/surgery (specify primary diagnosis) _____ ☐ Pregnancy (give due date) _____ ☐ Post-Partum (give delivery date) _____ ☐ Other (specify) _____ • I certify that this student is physically unable to attend school because of their own medical condition for _____ weeks starting _____. • I certify that this student is physically unable to attend school because of their pregnancy starting _____ and continuing for _____ weeks due to their medical condition.* • I certify that this student is physically unable to attend school for _____ week's post-partum due to their own medical condition.* * Call school or tutor with delivery date. If delivery or recovery is complicated and more recovery time is needed, submit an extension for longer service.			
Name of Provider:	Telephone number:	Business Address:	
Signature:	Date:		
SECTION 2 - FOR SCHOOL DISTRICT USE			
Tutor's name:	Telephone number:	School contact:	Position:
Reviewed by:	Date:	Start date: _____ # of Weeks: _____	☐ Approved ☐ Denied
Questions? Call Health Services: 509-526-8507			