REQUEST FOR HOME/HOSPITAL (H/H) SERVICES

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

SIGNATURE DATE

BUSINESS ADDRESS

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