HOME/HOSPITAL INSTRUCTOR PROGRAM
REQUEST FOR SERVICES

Home/hospital instruction is provided to students enrolled in a public school who are temporarily unable to attend school for an estimated period of four weeks or more because of physical and/or mental disability or illness." OSPI Bulletin No. 031-18

The following request form needs to be signed by the parent/guardian of children placed in the Home/Hospital Instructor Program in Bellingham Public Schools.

I, _____, request that my child, _____, be considered for in the Home/Hospital Instructor Program.

HOME/HOSPITAL INSTRUCTOR PROGRAM
PARENT/GUARDIAN AGREEMENTS

It is assumed that when you sign this statement:

1. An adult family representative must be on the premises and available during the entire teaching period.
2. Parent/guardian is expected to establish regular study periods for the child as suggested by the classroom teacher and approved by the qualified medical practitioner.
3. A teaching situation in a home or in a hospital should be as free from distraction as possible.
   a. Adaptation or revision of hospital routines may be necessary to ensure interruption-free lesson time.
   b. Adjustment in a family routine may be necessary to ensure the best teaching environment.

Child's Name: _____

Parent/Guardian Name: _____

Signature: _____

Phone: _____

Email: _____

Date: _____

Bellingham Public Schools
a collective commitment

REQUEST FOR HOME/HOSPITAL INSTRUCTION

Please Print

This section to be completed by Parent/Guardian

STUDENT NAME (Last, First, Middle)	☐ Male ☐ Female *Optional*	Grade	Contact Phone
Is this student enrolled in a Special Education Program? ☐ Yes ☐ No			

This section to be completed by Qualified Medical Practitioner

DIAGNOSIS: **CODE: (ICD-9-CM)**

- ☐ DISEASE/INJURY (specify primary diagnosis) _____ _____
- ☐ DRUG/ALCOHOL TREATMENT _____ _____
- ☐ PREGNANCY _____ _____
- ☐ OTHER* (Specify) _____ _____

*Prior telephone approval required

I CERTIFY THAT THIS STUDENT IS UNABLE TO ATTEND PUBLIC SCHOOL FOR _____ WEEKS
A minimum of 4 weeks, maximum of 18 weeks, consecutive or intermittent

NAME & TITLE of Qualified Medical Practitioner:	SIGNATURE	DATE
BUSINESS ADDRESS	CITY/STATE	PHONE

This section to be completed by Bellingham Public Schools

This Request is: ☐ Original ☐ Extension	MO	DAY	YR
Beginning Date of Instructional Time or Extension:			

District Authorization	Date

MAIL TO: Bellingham Public Schools, Home/Hospital Administrators, 1409 18th Street, Bellingham WA 98225