



WESTERN PLACER UNIFIED SCHOOL DISTRICT

600 Sixth Street Suite 400 Lincoln, CA 95648
916-645-6350-FAX 916-645-6356

Home/Hospital Instruction

DOCTOR'S VERIFICATION

At a parent/guardian's request, Home/Hospital Instruction must be provided to a student with a temporary disability which makes school attendance impossible or inadvisable. Home/Hospital Instruction is provided in the child's home or hospital setting, one hour of instruction for each day of regular program until the student can return to school.

Student Name: _____ School: _____

Parent Name: _____ Teacher/Counselor: _____

Address: _____ Grade: _____

Phone: _____ Cell/Work: _____

This is to verify that the student named above is in my professional care and I have determined that this student is temporarily disabled. He/she will be unable to attend school. **(Limit 8 weeks.)** This student does not have a contagious disease that will endanger the health and safety of a Home/Hospital Instructor through such instructional service.

Diagnosis: _____

Anticipated date to return to school: _____

Hospital (if applicable): _____

Physician Signature _____ Date _____

Printed Name of Physician _____ Phone _____

Parent must complete and submit both the Request for Home/Hospital Teacher Form and the Doctor's Verification Form (Elementary or Secondary) for approval.