

PARENT REQUEST FOR HOME/HOSPITAL SERVICES

Student's Name: _____ Grade: _____ Date of Birth: _____

Home Address: _____ City: _____ Zip Code: _____

Parent/Guardian Name: _____ Phone: _____

Teacher's Name: _____ School: _____

Last Date of Attendance: _____

Name of Doctor: _____ Office phone: _____

Date last seen by Doctor: _____

Has the Doctor advised to keep the child home and out of school? Yes ☐ No ☐

If "Yes", for how long? _____

Is child presently in the hospital? Yes ☐ No ☐ Hospital Name: _____**Authorization from Parent/Guardian**

The Lawndale Elementary School District is hereby authorized to consult the doctor whose name I have given in connection with this request for Home/Hospital Services.

Parent/Guardian Signature_____
Date**DO NOT WRITE BELOW THIS LINE PLEASE**_____
Student Support Services Director Signature: _____ Date: _____

Comments:
