STANWOOD-CAMANO SCHOOL DISTRICT
HEALTH SERVICES

Request for Home Hospital Services

Student Name:	School:	
Parent Name:	Grade:	Gender: Male ☐ Female ☐
Parent Phone Number:	School Contact:	Phone:

SECTION 1 – THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

Disease/Injury/Surgery (primary diagnosis):

Drug/Alcohol Treatment, Pregnancy, Other* (describe):

I certify that this student is unable to attend public school for at least 4 cumulative but no more than 18 weeks.

Office Name:	Office Address:
Print Name of Qualified Medical Practitioner:	Phone Number:
Signature	Date:

SECTION 2 – THIS SECTION FOR SCHOOL DISTRICT USE

Is this student enrolled in a special education program? YES ☐ NO ☐

Is an IEP team meeting required for this student? YES ☐ NO ☐

Names of building staff recommending Home Hospital be established:

Administrator:	Building or district nurse:
Classroom teacher:	Case manager (if applicable):

Beginning date of Instructional services:

Staff member assigned to provide services:

School District Admin Authorization:	Date:

Revision 1.15.26

Stanwood Camano SD Health Services
Attn: Mary Hoffman, District Nurse
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