# PORT TOWNSEND SCHOOL DISTRICT NO. 50

## REQUEST FOR HOME/HOSPITAL INSTRUCTION

| School District Contact | Telephone Number |
|---|---|
| | |

| Student Name (Please print) Last | First | Middle |
|---|---|---|
| | | |

| Date of Birth | School or Program | Student Grade Level |
|---|---|---|
| _____/_____/_____ MM DD YYYY | | |

### 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. (Minimum four [4] and maximum 18 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:

| | | |
|---|---|---|
| | | |
| MM | DD | YYYY |

Note: Beginning date on extension request must consecutively follow ending date of original

_____ _____ _____

School District Authorization Date Contact Telephone Number