REQUEST FOR
HOME/HOSPITAL (H/H) SERVICES
2019-2020 School Year

SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle) Please Print	
CONTACT PERSON	TELEPHONE NUMBER	STUDENT GRADE LEVEL	GENDER ☐ Male ☐ Female

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.

BUSINESS ADDRESS

TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER

SIGNATURE DATE

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:

MO	DAY	YEAR

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

SCHOOL DISTRICT AUTHORIZATION DATE

CONTACT TELEPHONE NUMBER

SAMPLE