University Place School District
3717 Grandview Drive West
University Place, Washington 98466

REQUEST FOR HOME/HOSPITAL INSTRUCTION

School District Name: University Place School District	
District Contact Person:	Telephone Number:

Student Name (Last, First, Middle) Please Print:	
Student Grade Level:	Gender: ❑ Male ❑ Female

Parent/Guardian Name:
Home Address:

Home Phone Number:	Work/Cell Number:

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.

Type/print Name of Qualified Medical Practitioner:		Business Address:
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:

Month	Day	Year

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

______________________ School District Authorization

______________________ Date

______________________ Contact Telephone Number

CH:ds Home/Hospital Forms 11/05