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