Shelton School District No. 309 Special Services

700 S. 1st Street Shelton, WA 98584
www.sheltonschools.org Phone: (360) 426-2151 Fax: (360) 426-9727

REQUEST FOR HOME/HOSPITAL* INSTRUCTION

**Home/Hospital (H/H) Services are provided in a student's home. Virtual or remote instructional support is not considered H/H services.*

Student: _____ Birthdate: _____ Gender: _____ Grade: _____

Parent/Guardian: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____

School: _____ Homeroom/Classroom Teacher: _____

Section I

This section is to be completed by a qualified medical practitioner:

☐ ***Doctor of Medicine (M.D.)*** ☐ ***Doctor of Osteopathy (D.O.)*** ☐ ***Doctor of Naturopathy (N.D.)*** ☐ ***Doctor of Dentistry (D.M.D.)***
☐ ***Doctor of Chiropractic (D.C.)*** ☐ ***Physician's Assistant (P.A.)*** ☐ ***Advanced Registered Nurse Practitioner (A.R.N.P)***
☐ ***Certified Nurse Midwife (C.N.M.)***

DIAGNOSIS: [ ] Disease/Injury/Surgery (primary diagnosis): _____

_____

[ ] Drug/Alcohol Treatment

[ ] Other (describe): _____

_____

I certify that this student is unable to attend public school for _____ weeks.
(Home/Hospital tutoring can only be provided for students absent a minimum of 4 weeks and may not exceed 18 weeks.)

_____ _____ _____
Type/Print Name of Qualified Medical Practitioner Signature Date

_____ _____
Business Address Contact Phone Number

Section II - *This section is for school district use only.*

Is this student enrolled in Special Education: ☐ Yes ☐ No

If the student is eligible to receive Special Education services, does the IEP team need to meet? ☐ Yes ☐ No

Check One: ☐ Original Request ☐ Extension

NOTE: Beginning date on extension request must consecutively follow ending date of original request. Any extensions beyond 18 weeks require OSPI approval.

Beginning date of instructional time or extension: _____ /_____ /_____ *(Month/Day/Year)*

_____ _____ _____
School District Authorization Date Contact Phone Number

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