



# GRANITE FALLS SCHOOL DISTRICT # 332

205 N Alder • Granite Falls, WA 98252

Phone: (360) 283-4311 • Fax: (360) 925-6477

## REQUEST FOR HOME/HOSPITAL INSTRUCTION

SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle) Please Print	
CONTACT PERSON	TELEPHONE NUMBER	STUDENT SCHOOL/GRADE LEVEL	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female

### SECTION 1—THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

#### DIAGNOSIS:

- Disease/Injury/Surgery (primary diagnosis): \_\_\_\_\_
- Drug/Alcohol Treatment \_\_\_\_\_
- Pregnancy \_\_\_\_\_
- Other \* (describe): \_\_\_\_\_

WAC 392-172A-02100 states, "Home or hospital instruction shall be provided to students who are unable to attend school for an estimated period of **four weeks or more** because of physical disability or illness."

I certify that this student is unable to attend public school for \_\_\_\_\_ weeks. Beginning date: \_\_\_\_\_

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 / \*Ending Date: \_\_\_\_\_
- 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
-------------------------------	------	--------------------------