

REARDAN-EDWALL SCHOOL DISTRICT

2165P Form

P.O. Box 225 • East 215 Spokane Avenue

Reardan, Washington 99029

www.reardan.net

An Equal Opportunity Employer

REQUEST FOR HOME/HOSPITAL INSTRUCTION

Please Print

School District Name		Student Name (Last, First, Middle)	
Contact Person	Telephone #	Student 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) _____

I certify that this student is unable to attend public school for _____ weeks.

Type/Print Name of Qualified Medical Practitioner

Signature

Date

Business Address

Business 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

Beginning date of instructional time or extension:

MO	DAY	YR
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NOTE: Beginning date on extension request must consecutively follow ending date of original

SCHOOL DISTRICT AUTHORIZATION

DATE

CONTACT TELEPHONE NUMBER