ARLINGTON PUBLIC SCHOOLS

Request for Home/Hospital Instruction

Student Name _____ Grade _____ Gender _____

Parent/Guardian Name _____ Phone _____ - _____ - _____

Home hospital instruction is provided to students who are temporarily unable to attend school for an estimated period of four (4) weeks minimum to a maximum of eighteen (18) weeks because of a physical and/or mental disability or illness. The program does not provide tutoring to students caring for an infant or a relative who is ill.

SECTION 1 - THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER

Diagnosis

Describe reason:

I certify that this student is unable to attend public school for _____ weeks. *(Minimum of 4 weeks to maximum of 18 weeks.)*

Printed name of qualified medical practitioner _____ Signature _____ Date

Business Address

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: _____ End date: _____

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

Staff assigned: _____

Copy sent to Parent/Guardian by: _____ *Date:* _____

_____ School District Authorization

Date _____ Phone _____