PLEASE FAX THIS REQUEST BACK TO: (425) 356-1279

REQUEST FOR HOME/HOSPITAL (H/H) SERVICES

SCHOOL DISTRICT NAME	SCHOOL NURSE/TELEPHONE	STUDENT NAME: (Last, First, Middle) Please Print	
Mukilteo			
DISTRICT CONTACT PERSON	TELEPHONE NUMBER	STUDENT GRADE LEVEL	GENDER ☐ Male ☐ Female
Malisa Lewis	425 356-1284		

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. **Minimum 4 weeks Maximum 18 weeks**

BUSINESS ADDRESS

TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER

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: MO DAY YEAR

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

SCHOOL DISTRICT AUTHORIZATION DATE

CONTACT TELEPHONE NUMBER