Home Hospital Packet
2023-2024 School Year

Dear Parent/Guardian:

We have received your request to be considered for the home/hospital instruction program. Before proceeding, please be aware of the following:

1. Service is provided for students unable to attend school due to injury or illness.
2. Service is provided for students expected to be out of school for at least four (4) consecutive weeks.
3. A physician must complete and sign the application form for home instruction. Home instruction cannot begin until the doctor has signed the form and it is returned to the school district.
4. Home instruction will stop when the student is able, in the doctor's opinion, to attend regular classes.

Home instruction cannot begin until the following forms are completed and processed by our office:

1. Student Information for Home / Hospital Instruction
2. Physician's Request for Home / Hospital Instruction (*must be signed by the physician*)

If you have any questions, please call Vern Mills (253) 583-5172 or (253) 583-5177

Enclosures:
Student Information for Home/Hospital Instruction
Physician's Request for Home/Hospital Instruction

Special Education Department
Clover Park School District ▪ 10903 Gravelly Lake DR SW, Room 1 ▪ Lakewood, WA 98499-1341
Vern Mills (253) 583-5172 or Tel: (253) 583-5177 ▪ Fax: (253) 583-5189

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Student Information for Home / Hospital Instruction

If you believe your student will qualify for home / hospital instruction, please do the following:

1. Complete this form.
2. Have the Physician's Request for Home/Hospital Instruction form (Section I only), completed and signed as soon as possible.
3. Return this form, together with the Physician's Request for Home/Hospital Instruction, to:

Special Education Department
ATTN: Home/Hospital
Clover Park School District
10903 Gravelly Lake DR SW, Room 1
Lakewood, WA 98499

4. If you have any questions, please call Vern Mills (253) 583-5172 or (253) 583-5177

Student Name: _____

Address: _____

_____

Telephone: _____ **Birthdate:** _____

Parent/Guardian: _____

Name of School: _____ **Grade Level:** _____

Name of School Counselor: _____

Nature of Illness / Injury: _____

_____

Name of Physician: _____

Physician Phone: _____

Has the student been hospitalized? ☐ Yes ☐ No

When and Where? _____

Parent/Guardian Signature _____

Date: _____

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PHYSICIAN'S REQUEST FOR HOME / HOSPITAL INSTRUCTION

SCHOOL DISTRICT NAME	
Clover Park School District	
CONTACT PERSON	TELEPHONE NUMBER

STUDENT NAME (Last, First, Middle) Please Print	
STUDENT GRADE LEVEL	GENDER ☐ Male ☐ 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	BUSINESS ADDRESS
SIGNATURE DATE	CONTACT TELPHONE 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 request.

SCHOOL DISTRICT AUTHORIZATION DATE CONTACT TELEPHONE NUMBER

FORM SPI E-310 (Rev. 8/07)