HOME/HOSPITAL INSTRUCTION
EXTENSION OF SERVICES

(To be considered for an extension of your student's home/hospital application, please complete this extension form)

Student Name_____
DOB_____
Student ID#_____

I. MEDICAL INFORMATION – to be completed by Physician, Psychiatrist or Clinical Psychologist. Please fill out completely and print clearly.

Dear Physician/Psychiatrist or Clinical Psychologist:

The parent/guardian of:

_____ _____
Student Name Date of Birth

has requested an extension of their home/hospital instruction for their child during their illness. Home/hospital instruction provides 5 hours a week of in home instruction. ***This application must be renewed by medical verification every 6 weeks***. Please complete this form and return it to:

_____ _____
School Nurse School Site

_____ _____
Phone Number/Email Address Fax Number

Complete the following:

_____
Today's Date

Current Diagnosis/Disabling Condition: _____

1. Is this a communicable disease? ☐ Yes ☐ No
   If yes, is condition transmitted via casual contact ☐ Yes ☐ No
   If yes, when is student no longer contagious? ☐ Yes ☐ No
   Is emotional condition a possible threat to a teacher? ☐ Yes ☐ No

   How does medical/emotional condition prevent school attendance? _____

   _____

2. Is school attendance possible with modifications: ☐ Yes ☐ No
   Explain: _____

   _____

3. Anticipated duration of home/hospital instruction: _____

4. Describe any necessary limitation of physical activity: _____

   _____

_____ _____
Physician/Psychiatrist /Clinical Psychologist Signature/Date Email Address

_____ _____
Mailing Address Phone Number/Fax Number

_____ _____
Signature Approval of Pupil Services Director Date

cc: Counselor, Administration Revised 8/28