

Tehama County

Special Education Local Plan Area

A Cooperative Activity of the County's School Districts and Department of Education

Request for Home and Hospital Instruction

School/Program Name	Student Name (Last, First, Middle Initial) Please Print		
Contact Person/Teacher	Telephone Number(s)	Student Grade Level	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
SECTION 1: TO BE COMPLETED BY THE QUALIFIED MEDICAL PRACTITIONER			
Primary Diagnosis/Condition that requires Home Hospital Instruction:			
<input type="checkbox"/> Disease			
<input type="checkbox"/> Injury			
<input type="checkbox"/> Surgery			
Student is to remain out of school for _____ weeks			
Recommendation for student tolerance for instruction not to exceed _____ minutes per visit			
Type/print name of qualified medical practitioner		Business Address	
Signature		Business/Contact Phone Number	
SECTION 2 – TO BE COMPLETED BY TEHAMA COUNTY DISTRICT REPRESENTATIVE			
Request for Home Hospital Instruction Received		_____	
		Mm/dd/yyyy	
Addendum to the IEP for inclusion of Home Hospital Instruction		_____	
		Mm/dd/yyyy	
Beginning date of instruction under Home Hospital Instruction		_____	
		Mm/dd/yyyy	
Authorized Signature		Phone number	Mm/dd/yyyy

