Lynden School District

HOME/HOSPITAL PROCEDURES

Home/Hospital (H/H) services are provided to students enrolled in a public school who are temporarily unable to attend school for an estimated period of four weeks or more because of physical and/or mental disability or illness.

Students residing at Seattle Children's Hospital do not qualify for H/H services. Students caring for an infant or relative who is ill are not eligible for H/H services. H/H services are not provided during school vacations unless students are enrolled in a summer school program. H/H services cannot begin for a student if less than four weeks of school remain.

H/H services are **limited to a maximum of 18 weeks** per school year. Weeks of absences may be consecutive or intermittent but may not exceed the 18-week limit. To qualify for H/H services on an intermittent basis, the total school days of absences must be at least four weeks, but the time that the H/H services begins, and ends is no more than 18 weeks.

A student receiving H/H services may be reported on basic education/special education (P223/P223h) reports for two count dates.

Prior to providing H/H services, the student's parent or guardian can request H/H services by completing the Lynden School District **REQUEST FOR HOME/HOSPITAL INSTRUCTION** form (available on the District website).

The request for H/H services form should be submitted to Special Programs for approval and processing. School Principal or designee will assign a tutor. Special Programs will retain completed forms, as well as maintain documentation of actual number of weeks of H/H services.

The district's head nurse will act as the district's liaison with the student's medical provider and will monitor the student's progress on behalf of the district.

Lynden School District
REQUEST FOR
HOME/HOSPITAL INSTRUCTION

SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle) Please Print	
CONTACT PERSON	TELEPHONE NUMBER	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

SIGNATURE DATE

BUSINESS ADDRESS

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