COMMUNITY HIGH SCHOOL
DISTRICT 94

APPLICATION/MEDICAL CERITIFICATION FOR HOME/HOSPITAL SERVICES

APPLICATION: To be completed by Parent or Guardian (**please print**)

My child is unable to go to school and I request: ☐ Home Instruction ☐ Hospital Instruction

Student's Name____Birthdate______________________

Grade________________________School of Attendance______________________________________

Date Last Attended________________________________Home School District____________________

Parent/Guardian Name____

Address____Home Phone_______________

City/State____Work Phone_______________

Date______________________ ____
Signature of Parent/Guardian

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Medical/Psychiatric Diagnosis____

Home Instruction____

Hospital Instruction____

Date to begin____

Tentative duration of absence from school____

____ _______________________________________
Name of Physician (Please type or print) Date

____ _______________________________________
Address Signature of Physician

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Phone Number

- -

(For School use Only)

CONTACT PERSON FOR SCHOOL PLANNING PURPOSES:

☐ Home Tutor ☐ Hospital Tutor

_______________________________________ __________________________________
Name/Title Name of Hospital

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Telephone