



9430-B Lake Street * PO Box 759
Lower Lake, California 95457-0759
(707) 994-6475 * Fax (707) 994-0210
www.konoctiusd.org

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To be filled out by the physician:

Date: _____

RE: Request for Home Study for: _____ D.O.B. _____

School: _____ Parent: _____ Telephone: _____

Dear Physician:

In response to the home study request for the above student, we ask that you review the attached policy which was adopted by the Board of Trustees on December 17, 1991 and revised November 17, 2004. In order to proceed, we will need a written description from you of the disabling condition. Please note that “**temporary disability**” means a disability after which the pupil can reasonably be expected to return to regular day classes without special intervention. Other educational placements will be utilized if the disability is long term. Please complete and sign the lower portion of this letter. Thank you.

1. Please describe the disabling condition: _____

2. Can the pupil be reasonably expected to return to regular day classes or an alternative education program or their existing special education program, if any? ____ Yes ____ No

If **no**, what intervention would be needed? _____

3. Home Instruction to Begin Date: _____ End Date (Approx.): _____

4. Will the student expose the home teacher to any contagious disease that can be transmitted by casual contact? ____ Yes ____ No

Physician's Name (Please print): _____

Physician's Address: _____

Telephone number: _____ Fax: _____

Physician's Signature: _____ Date: _____