Konocti Unified School District
Climbing To New Heights

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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:_____