TANGIPAHOA PARISH SCHOOL SYSTEM
APPLICATION FOR HOSPITAL/HOMEBOUND INSTRUCTION

After completion, forward this form to Bess Kolwe, Homebound Coordinator, 59656 Puleston Road, Amite, LA 70422

SECTION A *(to be completed by parent and/or school)*

STUDENT'S NAME_____ AGE____ SEX____ GRADE____

DATE OF BIRTH_____ SCHOOL_____ TEACHER_____

PARENT'S NAME_____ TELEPHONE _____

PARENT'S ADDRESS_____
street *city* *state* *zip*

CLASSROOM SETTING: _____REGULAR EDUCATION _____SPECIAL EDUCATION

REASON FOR APPLICATION: ___ILLNESS ___INJURY __PREGNANCY ___EXPULSION ___LRE_____

SECTION B *(to be completed by properly certified physician)*

ILLNESS, INJURY, HOSPITAL RECOVERY: The undersigned certifies that the above-named student is unable to attend school for the following reason(s). Please give specific medical diagnosis with brief description.

_____

PREGNANCY: Expected delivery date: _____ Expected date to return to school: _____

The student is experiencing the following complications in her pregnancy or recovery which would be detrimental to her health or the health of the fetus/offspring:

_____

APPROXIMATE LENGTH OF TIME (WEEKS) HOMEBOUND INSTRUCTION WILL BE NEEDED

Number of weeks: __3 __4 __5 __6 __7 __8 __9 __10 __11 __12

The undersigned hereby certifies that the proper treatment and convalescence for this incapacitating condition will necessitate the student needing homebound instruction for a period of at least 3 weeks, during which time the student will be unable to attend regular or special classes in school. The maximum time for services is 12 weeks. An extension may be approved by submission of additional application(s).

_____ _____ _____
Signature of Physician (rubber stamp not acceptable) *Date* *Physician's Address*

_____ _____
Physician's Name (please print) *Physician's Telephone Number*

SECTION C *(If a child is identified under IDEA, the I.E.P. team will consider the recommendation and determine if F.A.P.E. can be delivered.*

____APPROVED: ____HOURS PER WEEK FOR _____ WEEKS

____DECLINED

____INITIAL REQUEST ___EXTENSION ___NUMBER OF PREVIOUS REQUESTS

The undersigned certify that the above-named student meets criteria for hospital/homebound services:

_____ _____ _____ _____
Signature of Assistant Superintendent *Date* *Signature of Homebound Coordinator* *Date*