Tangipahoa Parish School System
Application for Hospital/Homebound Instruction

A. To Be Completed by Parent or School
Student’s Name__________________________________________ Grade______________
Student’s School_________________________________________ Date of Birth_____________
Parent Name____________________________________________ Phone (____)____________
Address___________________________________   City_____________   Zip___________
Classroom Setting:  □ Regular Education  □ Special Education  □ 504
Reason for Application:  □ Illness  □ Injury  □ Pregnancy  □ Expulsion  □ LRE

B. To Be Completed by Properly Certified Physician
1. 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)
   _____________________________________________________________________________
   _____________________________________________________________________________

2. Pregnancy
   a. Expected delivery date_____________ Expected date to return to school_____________
   b. 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/offset.
   __________________________________________________________________________
   __________________________________________________________________________

3. Approximate number of weeks homebound instruction will be needed:
   ___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 three weeks, during which time the student will be unable to
attend regular or special classes in school and will be unable to participate in co/extra-curricular activities. The maximum time
for services is twelve (12) weeks. An extension may be approved by submission of additional application.

_________________________________  _______________________________________
Physician’s Signature (Rubber Stamp NOT Accepted)    Physician’s Address
_________________________________  _______________________________________
Physician’s Name (Please Print)                     Physician’s Phone Number

C. To Be Completed by Special Education Department
   □ Approved ______ Hours per week    ______ Number of Weeks    □ Declined
   □ Initial Request    □ Extension
   The undersigned certify that the above-named student meets criteria for Hospital/Homebound Services

Assistant Superintendent’s Signature  Date    Homebound Coordinator’s Signature  Date

Mail To:  ATTN:    Bess Kolwe, Homebound Coordinator
           Tangipahoa Parish School System – Title I Resource Center
           500 East Pine Street
           Amite, LA 70422