

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. The following information is required from the treating physician:

A detailed statement provided on letterhead explaining the medical condition and the impact to the student including how it prevents the student from physically attending school.

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/offspring.

3. Approximate number of weeks homebound instruction will be needed:

 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

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 eighteen (18) 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

Declined

Approved _____ Hours per week _____ Number of Weeks

Initial Request Extension

The undersigned certify that the above-named student meets criteria for Hospital/Homebound Services

Assistant Superintendent's Signature _____ Date _____

Homebound Contact's Signature _____ Date _____

Mail To: ATTN:Strader Cieutat
Tangipahoa Parish School System
Family Resource Center
1745 SW Railroad Avenue Hammond, LA 70403
Fax: (985) 429 - 9044