TANGIPAHOA PARISH SCHOOL SYSTEM
EST. 1896

APPLICATION FOR HOSPITAL/HOMEBOUND INSTRUCTION

COMPLETE THIS FORM AND MAIL TO: TPSS 59656 PULESTON ROAD

AMITE, LA 70422 ATTN: LISA FUSSELL, ASST. SUPERINTENDENT

SECTION A: THIS SECTION TO BE COMPLETED BY PARENT OR SCHOOL (PLEASE PRINT).	
STUDENT'S NAME:	GRADE:
STUDENT'S SCHOOL:	DATE OF BIRTH:
PARENT'S NAME:	PHONE:
ADDRESS:	
CLASSROOM SETTING: ▢ REGULAR EDUCATION ▢ SPECIAL EDUCATION	
REASON FOR APPLICATION: ▢ ILLNESS ▢ INJURY ▢ PREGNANCY ▢ EXPULSION ▢ LRE	

THE FOLLOWING INFORMATION (SECTION B: 1, 2, & 3) IS REQUIRED FROM THE TREATING PHYSICIAN.

SECTION B: #1: ILLNESS, INJURY, HOSPITAL RECOVERY

THE UNDERSIGNED CERTIFIES THAT THE ABOVE NAMED STUDENT IS UNABLE TO ATTEND SCHOOL FOR THE FOLLOWING REASONS (INCLUDE THE SPECIFIC MEDICAL DIAGNOSIS WITH A BRIEF DESCRIPTION.):

_____

_____

SECTION B: #2: PREGNANCY	
EXPECTED DELIVERY DATE:	EXPECTED RETURN TO SCHOOL DATE:

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:

_____

_____

SECTION B: #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

PHYSICIAN'S NAME: _____ SIGNATURE (STAMP NOT ACCEPTED): _____

ADDRESS: _____ PHONE: _____

SECTION C: TO BE COMPLETED BY SPECIAL EDUCATION DEPT. ▢ INITIAL REQUEST ▢ EXTENSION

▢ DECLINED ▢ APPROVED: _____HOURS PER WEEK _____NUMBER OF WEEKS

THE UNDERSIGNED INDIVIDUALS CERTIFY THE ABOVE-NAMED STUDENT MEETS THE CRITERIA FOR HOSPITAL/HOMEBOUND SERVICES:

_____ _____ _____ _____

SIGNATURE OF HOMEBOUND CONTACT | DATE | SIGNATURE OF ASSISTANT SUPERINTENDENT | DATE