APPLICATION FOR HOSPITAL/HOMEBOUND INSTRUCTION

COMPLETE THIS FORM AND MAIL TO: TPSS Family Resource Center, Attn: Strader Cieutat

1745 SW Railroad Ave. Hammond, LA OR Fax to 985-429-9044

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.):

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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:

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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):____________________________ DATE:__________

ADDRESS:____ PHONE: ____________________

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

◯ DECLINED ▢ APPROVED:________HOURS PER WEEK_______NUMBER OF WEEKS Homebound Teacher___________________

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

______________________	__________	______________________	__________
SIGNATURE OF HOMEBOUND CONTACT	DATE	SIGNATURE OF SPED CONTACT	DATE