

**STUDENT INFORMATION (PLEASE PRINT)**

<input type="text"/>	<input type="text"/>	<input type="text"/>
Student's Legal Last Name	First Name	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address Number and Street Name – Apt. #	City	Zip Code
<input type="text"/>	<input type="text"/>	
Home Phone Number	Alternate Phone Number	
<input type="text"/>		<input type="text"/>
School		Grade

Is the above named child unable to attend school because of a medical condition?  Yes  No

Can the pupil attend school on a part-time basis?  Yes If yes, for how long: \_\_\_\_\_  No  
*\*\*Pupils able to attend school part-time are expected to do so and do not qualify for homebound/hospitalized service.*

Medical Condition / Diagnosis: \_\_\_\_\_

Is the student's medical condition contagious?  Yes  No

Does the medical condition require the child to be confined to the home or hospitalized?  Yes  No

Can the child physically participate in instructional services at home or while hospitalized?  Yes  No  
*\*\*Instructional services are 45 minutes two (2) days a week and Special Education instructional services are 60 minutes two (2) days a week.*

Child restriction/s: \_\_\_\_\_

What is the probable length of time the student will require homebound services Weeks: \_\_\_\_\_ Months: \_\_\_\_\_

Date when services may begin: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Office use only**

Reviewed and Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Service Provider: \_\_\_\_\_ Service Start Date: \_\_\_\_\_