

**APPLICATION FOR HOSPITAL/HOMEBOUND PROGRAM
IBERVILLE PARISH SCHOOL SYSTEM
DEPARTMENT OF INSTRUCTIONAL PROGRAMS**

PARENT/GUARDIAN: PLEASE RETURN THIS TWO-PAGE COMPLETED FROM TO YOUR CHILD'S HOME SCHOOL

Name _____ SS# _____ DOB _____ Sex _____ Grade _____

School _____

Parent(s) Name _____ Home Ph. _____ Wk# _____ Cell# _____

Student's Home Address _____ City _____ Zip _____

Name of responsible adult to be present during instruction: _____

MEDICAL CERTIFICATION – TO BE COMPLETED BY A PHYSICIAN

Illness, injury, Hospital Recovery

A. The undersigned certifies that the above named student is unable to attend school for the following reason(s): **GIVE SPECIFIC DIAGNOSIS AND COMPLETE SCREENING/REFERRAL CHECKLIST**

B. **If you are pregnant**, complete the following:

1. The student is experiencing the following complications in here pregnancy which would be detrimental to her health or the health of her unborn child. _____

2. Actual Date of Delivery: _____

Postpartum recuperation required*? YES NO (*NOT TO EXCEED SIX WEEKS)

Communicable Status

A. Is this student contagious at this time? YES NO

B. Can this illness be transmitted by the hospital/homebound teacher to another homebound student? YES NO

Duration

The expected duration of the condition which prevents school attendance is: (A TIME PERIOD MUST BE CHECKED. IF MORE THAT TWELVE WEEKS, A PHYSICIAN UPDATE MUST BE SUBMITTED AT THAT TIME).

3 weeks 4 weeks 5 weeks 6 weeks 7 weeks 8 weeks 9 weeks

10 weeks 11 weeks 12 weeks

Physician's Name: _____ Phone# _____
Print Legibly or Type Phone Required

Address _____ City _____ State _____ Zip _____

Physician's Signature _____ Date _____

Rubber stamp signature is not acceptable