It's about KIDS
Cabot Public Schools

Application for Homebound Instruction

Student Information

Name _____ Grade _____ Date of Birth _____
Last First Middle

School _____ Counselor _____

Please check all that apply: ___ 504 Plan ___ ESL services ___ Special Education services/IEP ___ GT/AP courses

Parents/Guardian _____ Phone _____ Address _____

The signature confirms the parent/guardian has received Cabot Public School District's Homebound Instruction Information page about homebound services.

Parent/Guardian Signature _____ Date _____

Physician's Report

This form must be completed by the student's physician and returned to the Director of Counseling, Cabot Public Schools, 602 North Lincoln, Cabot, AR 72023, fax to 501-843-0576, or email terena.woodruff@cabotschools.org This information is essential in determining eligibility for services.

Physician's Name (printed) _____ Clinic Name _____

Address _____ Phone _____ Fax _____

How long has this student been a patient? _____ Diagnostic/Medical Label _____

Briefly explain how this illness/injury prevents school attendance _____
_____

Prognosis including length of homebound (***specific date or length is required***) _____
_____

Please rate symptoms Chronic Acute Mild Moderate Severe

Physician's Signature _____ Date _____

School Use Only

___ Approved ___ Denied Begin Date _____ Projected End Date _____

Assigned Teacher _____ Date services ended
_____

Comments _____

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Authorized by _____ Date _____