

FAYETTEVILLE PUBLIC SCHOOLS
FAYETTEVILLE, ARKANSAS

APPLICATION FOR HOMEBOUND SERVICES

Students Name _____ Sex _____ Date of Birth _____

School _____ Grade _____ SS# _____

Parent/Guardian _____

Address _____ Phone _____

I request that homebound services be provided for the above-named student.

Parent/Guardian Signature _____ Date _____

The section below is to be completed by physician or psychologist.

The above-named student is unable to attend school due to _____

It is estimated that his condition will exist until (date) _____

Physician's Signature _____

Printed Name _____

Date _____

This form, when completed, should be returned to the principal or the counselor of the student's school.

Principal's/Counselor's Signature _____

Comments _____

(FOR OFFICE USE ONLY)

Approved _____

Teacher Assigned _____

Rejected _____

Effective Date _____

Date _____

Ending Date _____

Note: Approval of this application will provide a home teacher for up to three hours per week for the duration of the student's disability.

Copy to file, parent or guardian, school.