WARREN COUNTY SCHOOLS	NOTICE OF REQUEST FOR HOMEBOUND SERVICES
Student Name:	School Name:
Street Address:	Parent Name:
City: State: Zip Code:	Work Number:
Home Phone: Student Number:	Student's DOB: Age:

STATEMENT OF HEALTH PROFESSIONAL

This statement to be completed by the Licensed Physician, Licensed Psychologist, or Licensed Social Worker providing treatment and verification of the condition requiring the absence from school.

Diagnostic Statement: ____________________________________ Date of Examination: _____________

Reason for student's inability to attend school: ____

Estimated time student will require educational services: Beginning Date _________________________

Estimated Returning Date ___________________________________

Can student attend school part-time? No ☐Yes ☐Approximate # of hours can attend school _______

Indicate physical or psychological limitations in the provision of educational services (and risk of

contagion, if applicable) ____

Address of health professional: (please print)

____

Name Street Address City State Zip Telephone

____

Signature of Physician or Health Professional Date

By signing this form, I verify that the above named student has a medical condition that necessitates that he/she be absent from school during the time stated.

____ ____________________________________

Parent's Signature Date

For School Use Only	
School Administrator Authorization	
Special Education Services Currently: Yes ☐ No ☐	
Teacher Assigned:	School Contact:
_______________________________ School Administrator Signature	_______________________________ Date
School District Authorization	
Approved ☐ Denied ☐ Reason Denied:	
_______________________________ Student Services Administrator Signature	_______________________________ Date

Original: Parent Copy:_____Director of Student Services SS-132 Revised 10/05/04

_____School