SCOTLAND COUNTY Schools

322 South Main Street
Laurinburg, North Carolina 28352
(910) 276-1138 • fax (910) 277-4310

Homebound Services Request and Physician's Statement

PARENT/GUARDIAN REQUEST:

I, ________________________________, **request that my child,** _____________________________
Parent / Guardian Name **Student's Name**

Receives Hospital/Homebound services for the time indicated by the attending physician.

____ ___________________________________
Parent / Guardian Signature **Date**

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PHYSICIAN'S STATEMENT

Child's Name ______________________________________**Age** _____ **Date of Birth** ___________

Address (house # and street name) **Working Phone#**
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Parent / Guardian ____

Nature and Extent of Disability (Please be specific) ______________________________________
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Physical and/or psychological limitations under which child can/cannot perform school work successfully.
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Date services begin: ____

***Date services expected to end:** ____

In the case of pregnancy – Expected Due Date: ____

<u>* If the student is pregnant, services automatically begin on the date that the doctor indicates and continues for three (3) weeks after delivery unless the physician indicates otherwise.</u>

Physician's Name PRINTED ____

Physician's Office Phone # ____

Physician's Signature ____

Date ____

<u>SCHOOL PRINCIPAL'S APPROVAL:</u>

____________________________________	____________________________
Principal's Signature	**Date**