

**HOBBS MUNICIPAL SCHOOLS
REQUEST FOR HOMEBOUND INSTRUCTION**

Name of Student: _____ D.O.B. _____

School: _____ Grade _____

Teacher(s): _____

Parents/Guardians: _____

Address: _____ City _____

Cell Phone: _____ Work Phone: _____

Referred by: _____ Date: _____

Remarks: _____

PHYSICIAN'S STATEMENT

Diagnosis: _____

How does this diagnosis/condition impact the student's ability to attend school: _____

Dates unable to attend school: _____

Doctor' signature: _____ Date: _____

Address: _____ Phone: _____

Please feel free to add any additional information that will help us to more effectively meet the needs of the student.

Return this form to the School Nurse.

Date Received by School Nurse: _____ Date: Medical Necessity Confirmed: _____

School Nurse: _____ Date: _____

Approve _____ Disapprove _____

Principal: _____ Date: _____

Approve _____ Disapprove _____

Counselor: _____ Date: _____

Approve _____ Disapprove _____

Date Received by Director of Nursing: _____

Special Services Signature/Title: _____ Date: _____

Approve _____ Disapprove _____

Date Sent to Homebound Instructor: _____