



## Department of Student Services

Julien Frazier, Director  
LaToyra Weston, Admin. Asst.  
Phone: 734.697.1009  
Secure Fax: 734.822.0212  
Administration Building  
555 W. Columbia Ave  
Belleville, MI 48111

### *Homebound and Hospitalized Instruction Request Form*

#### **Student Information**

Name: \_\_\_\_\_  
First Last

School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Student Address: \_\_\_\_\_

#### **Physician Certification (This section must be completed by a MD, DO, or PA only)**

Nature of the medical condition: \_\_\_\_\_

Duration of the confinement: \_\_\_\_\_

I certify that the above-named student is unable to attend school for any part of the school day due to a medical condition that requires the student to be hospitalized or confined to the home during regular school hours for more than 5 consecutive school days.

Attending Physician's Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

#### **Parent/Guardian Acknowledgement**

I, \_\_\_\_\_ the parent/guardian of the above-named student, understand that homebound and hospitalized services is a guided self-study program designed to help my student keep up with schoolwork while my student is unable to attend school. I also understand that my student will be required to do schoolwork outside of scheduled teacher sessions to make progress. I understand that I will need to provide supervision during teacher visits and support my student with learning activities to the extent possible outside of those visits.

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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