ATLANTA PUBLIC SCHOOLS
Making A Difference

OFFICE OF STUDENT PROGRAMS AND SERVICES
REFERRAL FOR HOMEBOUND
STUDENT SUPPORT TEAM COMPLIANCE

(In order for referral to be processed, Sections I and II must be completed in full)

I. STUDENT INFORMATION – To be completed by principal/designee and parent and forwarded to:

__________________________ ______________________________ ___________________
Physician Address Phone #

Student's Name ___________________________ DOB___________ ID#___________________

Address__________________________________ Zip_____________ Phone_________________

School_______________________________ Grade________ Homeroom Teacher_______________

Principal's Signature___________________________________ Date__________________________

SST Chairperson's Signature_____________________________ Date__________________________

I agree for my child to receive Homebound Services. I am aware that I can participate in which educational plans are made for him/her. Also, I am aware that AN ADULT OVER THE AGE OF 21 MUST BE PRESENT IN THE HOME DURING INSTRUCTIONAL SESSIONS.

Parent's Signature_____________________________ Date_____________________
Student's Signature _____________________________ Date_____________________
☐ Student is 18 years old (Parent signature not required)

II. MEDICAL CERTIFICATION - All items MUST be addressed by a licensed physician.
☐Medical Information obtained ☐Medical release form obtained
Date of examination_______________________ Date of next examination___________________
Diagnosis________________________________ Is condition contagious? ___________________
Is student physically capable of participating in instruction? ___________________________________
Description of limitations or restrictions: ____
____
Can student be accommodated in an accessible building? Yes________ No________
Estimated length of time service is needed? From_______________ To____________________
Type of Homebound Services Recommended ☐Temporary ☐Intermittent ☐Long-term

Physician's Signature______________________________________ Date___________________

III. ~~OSPS USE ONLY~~
APPROVED___________________ DENIED BECAUSE____________________________
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Date Approved____________________________ Through___________________________
Approved by:_____________________________ Date______________________________

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It is the policy of the Atlanta Public Schools not to discriminate on the basis of race, color, sex, religion, national origin, age, or handicap in any employment practices, education programs or activities.