

**MCDOWELL COUNTY SCHOOLS****Referral for Homebound Services**

Student Name: \_\_\_\_\_ ID# \_\_\_\_\_  
 School: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Home /Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Student is anticipated to be absent from school at least 4 weeks.

Student's Last Date of Attendance: \_\_\_\_\_

Student's Projected Dates of Absence: \_\_\_\_\_

Reason for Referral: Please check box that applies:

- ☐ Accident victim
- ☐ Surgery
- ☐ Extended Illness
- ☐ Pregnancy
- ☐ Behavior/Anxiety

Currently identified: ☐ IEP ☐ 504 ☐ Not identified

Physician/Therapist note attached? Yes ☐ No ☐

\*Will not be processed without signed recommendation form

Amount of time served regular education \_\_\_\_\_

Amount of time served special education (if applicable) \_\_\_\_\_

Dates for monthly review (*Meet to review progress every 30 days and complete review form at each meeting*)

- 1)
- 2)
- 3)

Team member signatures and position:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Send copy of all forms to Director of Student Services and Director of Exceptional Children for signature: \_\_\_\_\_

☐ Director contacts homebound teacher