PARENT REQUEST
FOR HOSPITAL/HOMEBOUND SERVICES
Murray County Schools

Student's Name: _____ Grade: _____

Student's Birthdate: _____

School: _____

Home Address: _____

_____

Telephone: (Home) _____ (Cell) _____ (Work) _____

Directions To My Home: _____

_____

_____

_____

- I request hospital/homebound services from the Murray County School System for my child.
- I will ensure that an adult is present in the home or at the hospital when the teacher is providing instruction.
- I will provide a comfortable, quiet space for my child and the teacher to work in my home.
- I will see that my child has regular study time while he/she is enrolled in the hospital/homebound program.
- I understand hospital/homebound services are for three hours per week unless otherwise designated in an IEP.

Parent/Guardian Name (Print): _____

Parent/Guardian Name (Signature): _____ Date: _____

Relationship To Child: _____