HCS Horry County Schools INSPIRING POSSIBILITIES

PARENTAL DISMISSAL OF MEDICAL HOMEBOUND SERVICES

I. STUDENT INFORMATION (Please Print)

Student's Name:	Date of Birth:	Age:	Gender:	Grade:
School:	School Year:			

II. Date ___/___/___

III. Homebound Hours Remaining: ______________________

IV. Reason for Dismissal of Remaining Hours:

V. I agree to dismissal of remaining homebound hours for _________________________.
(student name)

_________________________________ _____________________________ ___/___/___
Parent/Guardian Signature Parent/Guardian (print name) Date

_____________________________________ ___/___/___
Homebound Coordinators Signature Date

cc: Parent
Homebound Instructor

*Signed original remains at the school