Child’s name ____________________ Location _____________ Date ________________

Reason for Home Bound Program:

Approval of Home Bound Services
Head Start Program Director’s signature: ______________________________

Approval may be faxed to Program Director at (573) 431-2129.

FOR FIRST VISIT Date initiated: __________________

What will occur for child to be able to return to the classroom?

I understand that:
1) The Homebound Program is designed to meet our particular set of circumstances at this time.
2) The program will include:
   a) the Head Start child, unless circumstances prevent this from occurring.
   b) an adult, preferably a family member.
3) Your child and the adult will need to meet with a Head Start staff member on a weekly basis.
4) The time will be: (day of the week) _____________________ at (time) ____________._

Parent’s signature: ________________________________________________

Head Start staff member signature: __________________________________

Area coordinator signature: _________________________________________

OUTCOMES AND ACTIVITIES DONE AT HOME BOUND VISIT
Outcome Activities Home theme: ________________________________

_______________________________________________________________

_______________________________________________________________

Name of book left with Reading Homework sheet ____________________________

Other support provided for the family: _________________________________

Note: Family advocates will provide the home bound visit at least monthly at which time services will be re-evaluated.

For entry: 1) ATTENDANCE  N = non-scheduled;  P or A = present/absent at home visit
       2) MEAL COUNT  N = non-scheduled on all classroom days
       3) FAMILY SERVICES Home Visit Description: Home Bound Service Area Code: ED

After computer entry, this form goes in the back of the green portfolio.

HOME-BOUND CONCLUSION  Date concluded: ____________ Site Manager initials: _______
**East Missouri Action Agency, Inc. Head Start**

**HOME BOUND VISIT**

Child’s name _______________________________ Date _______________

**OUTCOMES AND ACTIVITIES DONE AT HOME BOUND VISIT**

<table>
<thead>
<tr>
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Name of book left with Reading Homework sheet ________________________________

Other support provided for the family: ________________________________________________________________________________

Parent’s signature ______________________________________________________

Head Start staff member signature __________________________________________

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East Missouri Action Agency, Inc. Head Start
**HOME BOUND VISIT**

Child’s name _______________________________ Date _______________

**OUTCOMES AND ACTIVITIES DONE AT HOME BOUND VISIT**

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Other support provided for the family: ________________________________________________________________________________

Parent’s signature ______________________________________________________

Head Start staff member signature __________________________________________

For entry: 1) ATTENDANCE  N = non-scheduled;  P or A = present/absent at home visit

2) MEAL COUNT  N = non-scheduled on all classroom days

3) FAMILY SERVICES  Home Visit  Description: Home Bound  Service Area Code: ED

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