

**Homebound and Hospitalization Instruction
Verified Medical Reason**

Name of Child: _____ Date of Birth: _____

Address of Child: _____

Name of Parent(s): _____

Address of Parent(s) (if different from child): _____

This section below must be completed by the student's treating physician to verify a medical reason that prohibits the student from attending school. Upon completion, this form must be provided by the treating physician directly to the Manchester Public Schools, Director of Pupil Personnel Services at 45 North School Street, Manchester, CT 06042.

Contact Information for Treating Physician

Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

| Yes | No | Medical Verification |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I have consulted with school health supervisory personnel and have determined that the child's attendance at school with reasonable accommodations is not feasible. The contact information for the school health supervisory personnel for this matter at Manchester Public Schools is Suzanne Valade |
| <input type="checkbox"/> | <input type="checkbox"/> | The above-named child is unable to attend school due to a verified medical reason. |
| <input type="checkbox"/> | <input type="checkbox"/> | The child will be absent from school for at least ten (10) consecutive school days. |
| <input type="checkbox"/> | <input type="checkbox"/> | The child will be absent from school for short, repeated periods of time during the school year. |

The child has been diagnosed with: _____

*** Documentation supporting the above diagnosis MUST be submitted to the Manchester Public Schools along with this Medical Verification Form.**

The child is expected to be able to return to school on: _____

By signing below, I verify that the above information is accurate to the best of my professional knowledge.

Signature of Treating Physician

Date