Shepaug Valley Regional School District No. 12
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)

The 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 Shepaug Valley Regional School District No 12 Public Schools, care of *Allyson O'Hara* at *11A School St., Washington Depot, CT 06794.*

Contact Information for Treating Physician

Name:_____

Address:_____

Phone:_____ Fax:_____Email:_____

Medical Verification

Yes	**No**	
☐	☐	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 above-named child is unable to attend school due to a verified medical reason.
☐	☐	The child will be absent from school for at least ten (10) consecutive school days.
☐	☐	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 Shepaug Valley Regional School District No 12 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