Preston Public Schools

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 Preston Public Schools, care of _____ *[insert contact name]* at _____*[address]*.

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 Preston 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