

PLYMOUTH PUBLIC SCHOOL  
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 Plymouth Public Schools, care of Beth Melillo at 27 North Harwinton Avenue, Terryville, CT 06786.

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 contact information for the school health supervisory personnel for this matter at \_\_\_\_\_ Public Schools is:

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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.

**STATE FORM**

The child has been diagnosed with:

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\* Documentation supporting the above diagnosis **MUST** be submitted to the Plymouth 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

Revised: 10/8/13