

MEDICAL VERIFICATION FOR HOMEBOUND / HOSPITALIZATION

Pursuant to Section 388.1709 (1) of the State School Aide Act, public school districts shall provide appropriate instructional services, as determined by the district, to an enrolled pupil who is certified by an attending physician as having a medical condition that requires the pupil to be hospitalized or confined to the his/her home during regular school hours and that is expected to require hospitalization/confinement for a period longer than five days.

Student Name:	Birthdate:
Medical Condition:	
Medication(s):	
Anticipated Length of Hospitalization or confiner	
Start date: An	
As a certified physician, I acknowledge that this requires hospitalization or confinement to the hor	
Physician Signature:	Date:
Physician/Practice Information. Please type or pr	rint.
Physician's Name:	
Practice Name:	
Address:	Telephone Number:
When completed, please mail/fax to:	District Contact Name, Title
	District Name
	District Address
	District Phone District Fax