

ANSONIA PUBLIC SCHOOLS

Families, Schools, and Community – Working Together

42 Grove Street,
Ansonia, CT 06401

PH: (203) 736-5095
FAX: (203) 736-5098
www.ansoniam.org

SUPERINTENDENT
OF SCHOOLS:
Joseph DiBacco, Ed. D.
jdibacco@ansoniam.org

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 Ansonia Public Schools, care of *Director of Pupil Services* at 42 Grove St. Ansonia, CT 06401.

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 Ansonia Public Schools is:

☐ ☐ 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

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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 AnsoniaPublic 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