Clinton
PUBLIC SCHOOLS

HOMEBOUND & HOSPITALIZATION INSTRUCTIONS

VERIFIED MEDICAL REASON

This document is fillable using Adobe Acrobat or can be printed and completed by hand.

Name of student: _____ Date of Birth: _____

Address of student: _____

Name of parent(s)/guardian(s): _____

Address of parent(s)/guardian(s): _____
(if different from student)

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 Clinton Public Schools:

in care of (facility/individual): _____

at (address): _____

Contact Information for Treating Physician

Name: _____

Address: _____

Phone: _____ Email: _____

Medical Verification

Yes	No	
☐	☐	I have consulted with school health supervisory personnel and have determined the student's attendance at school with reasonable accommodations is not feasible.
☐	☐	The above-named student is unable to attend school due to a verified medical reason.
☐	☐	The student will be absent from school for at least ten (10) consecutive school days.
☐	☐	The student will be absent from school for short, repeated periods of time during the school year.

Administrative Offices | 137-B Glenwood Road | Clinton, CT 06413 | Phone: 860-664-6500 | Fax: 860-664-6580

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The student has been diagnosed with:

* Documentation supporting the above diagnosis MUST be submitted to the Clinton Public Schools along with this Medical Verification Form.

The student 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

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