

**Meriden 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 Meriden Public Schools, care of:**

***Donna Adduci Mik, 22 Liberty Street, Meriden, CT 06450- fax – 203-630-4436***

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: \_\_\_\_\_

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