Weston Public Schools

Homebound Instruction Request Form

(This form is to be filled out by the student's treating physician)

TO THE TREATING PHYSICIAN: Pursuant to the Connecticut State Department of Education regulations (specifically R.C.S.A. §10-76d-15), the following information must be provided to the district in order for a student to be eligible for homebound instruction. Please legibly complete this form. If you have any questions about this form, please contact Tracy Edwards, Director of Pupil Personnel Services. This completed form is to be provided to: Tracy Edwards, Director of Pupil Personnel Services.

Student's Name: ______________________________ Date of Birth: ______________________

Home Address: ____

Treating Physician's Name: ____

Address: __________________________________ Phone Number: ____________________

Email address (optional): ____

Please provide the information below: You are encouraged to attach extra paper as needed to this form in order to answer the questions as fully and completely as possible.

a. State the student's current diagnosis:

b. Please attach documentation to support this diagnosis including but not limited to a written statement, testing results, and/or medical records.

c. Is the student unable to attend school due to a verifiable medical reason? If yes, what is the reason?

d. Will the student be absent from school for at least 10 consecutive school days due to his or her condition?

e. Is the child's condition such that the child may be required to be absent for short repeated periods of time during the school year?

f. Have you consulted with school health supervisory personnel (i.e. the school nurse or the district's medical supervisor) and determined that the student's attendance at school is not feasible even with reasonable accommodations? If yes, please state the name of the school health supervisory personnel with whom you have consulted, the accommodations discussed, and the basis for determining that accommodations in school could not be provided.

The expected date the student will be able to return to school is: ____________________
mm/dd/yyyy

Signature of the Treating Physician: ___________________________ Date: __________________