AUSTIN INDEPENDENT SCHOOL DISTRICT
504 Services

Physician's Report: Other Health Impaired

Student: ______________________________ Permnum: ____________________
(Last) *(First)*

School: ______________________________ Date of Birth: ____________________

PROFESSIONAL EVALUATOR: Licensed Physician (specialty): ____________________

Please check one of the following:

❑ **NO** impairment exists.

❑ Impairment **DOES NOT** adversely affect educational performance.

❑ Based on my examination, the student appears to have limited ❑strength, ❑vitality, or ❑alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that is due to chronic or acute health problems and which adversely affect the student's educational performance

Type of Impairment (i.e., diagnosis):

❑ ADHD: type ____________________

❑ Heart Condition	❑ Sickle Cell Anemia	❑ Tuberculosis
❑ Asthma	❑ Diabetes	❑ Rheumatic Fever
❑ Hemophilia	❑ Epilepsy	❑ Cancer/Leukemia
❑ Nephritis	❑ Lead poisoning	

❑ Other: ____________________

EDUCATIONAL IMPLICATIONS

Functional implications of the impairment **at school** (e.g., precautions regarding the student's mobility, activity, cognitive ability, need for rest periods and special equipment, effects of any medication, need for medical updates):

❑ may require assistance or additional time to accomplish self-help skills (i.e., feeding, dressing, toileting)

❑ difficulty performing activities within the classroom (i.e., cutting, writing, etc.) and may require special adaptations

to the regular program including: ____________________

❑ difficulty maintaining alertness in the classroom: ____________________

❑ difficulty transferring on and off the bus independently

❑ difficulty with mobility and seating within a general classroom: ____________________

❑ may require additional rest periods: ____________________

❑ taking the following medication(s): ____________________

which is/are expected to have the following effects on classroom functioning: ____________________

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❑ seizure precautions: ____________________

❑ dietary restrictions:

❑ other: ____________________

Sources of educational information relied upon to make this determination:

Signature of Licensed Physician ____________________ Name (please print) ____________________

Address Telephone: ____________________

City/State/ZIP: ____________________ **Date of Report:** ____________________

This completed form will be considered by the student's 504 committee in establishing appropriate accommodations for 504 services within the school setting.

Original to: 504 Audit Folder
Copies to: Parent/Student, Teacher, Evaluation Staff
PHYSICIAN'S REPORT: OHI (01/2013)