

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: \_\_\_\_\_
- \_\_\_\_\_
- 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.**