Austin Independent School District

Department of School, Family and Community Education

PHYSICIAN INFORMATION REPORT

Student _____ DOB _____

School _____ Grade _____

Parent/Guardian _____

Home Phone _____ Cell Phone _____

Address _____

****HOMEBOUND SERVICES ARE FOR MEDICAL REASONS ONLY****

Diagnosis: _____

Date of Diagnosis: _____ **Communicable?** ☐ **Yes** ☐ **No**

Would providing any of the following accommodations in the school setting allow the student to remain in the regular school setting?

☐Rest Periods ☐Shortened Day ☐Use of Wheelchair ☐Limited Physical Activity

☐Elevator Use ☐Breaks as Needed ☐Restroom Pass ☐Movement in Uncrowded Hallway

☐Pass to Support Person ☐Nutritional Breaks ☐Water Bottle

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Is the student confined to the home or hospital bedside for a minimum of four consecutive weeks?

☐ Yes ☐ No

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Is the student physically able to perform school work with a Homebound teacher? ☐ Yes ☐ No

If yes, provide the anticipated period of confinement: _____ weeks or _____ months

(Please be specific, "unknown or indefinite" is not sufficient.)

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Licensed Physician's Signature: _____

Physician's Printed Name: _____ Date: _____

Phone Number: _____ FAX: _____

aisdhomebound@austinisd.org Phone: (512) 414-0184 or (512) 414-0148 FAX: (512) 414-0390

***The Physician's statement is not the sole determining factor in the committee decision-making process.**
9/2013