Bastrop
Independent School District

HOMEBOUND NEEDS ASSESSMENT
Professional Evaluation by Licensed Physician

Student Name:_____DOB:_____ School: _____Grade: ____

Parent Name(s)_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Date of physical exam or medical appointment: _____

Will you be conducting a follow-up exam? _____ If yes, how often? _____

Does the student have a chronic illness that will necessitate confinement at home for a minimum of four weeks (need not be consecutive) throughout the school year. ☐ Yes ☐ No

The period of confinement is expected to begin on(mm/dd/yyyy) _____ and end on (mm/dd/yyyy) _____. Beginning date may not be prior to the date this form was completed.

Specify the type of impairment (i.e., diagnosis):_____

Specify the severity of impairment (e.g. mild, moderate, severe):_____

Specify the functional implications of the impairment for the educational process (i.e. precautions regarding student's mobility, activity, cognitive ability; need for rest periods and special equipment; effects of any medication; need for medication; need for medical update):_____

_____

If the period of confinement is not expected to be continuous, describe the basis for your expectation that the student will be confined for a period of time totaling **at least four weeks** during the school year?

_____

What circumstances or conditions will necessitate confinement (e.g. chemotherapy treatment)?

_____

What are the criteria for the student returning to school? _____

Is the nature of the condition? ☐ physical ☐ psychological/psychiatric ☐combination

If the condition is psychological / psychiatric, are there services such as counseling or parent training that would facilitate the student's return to the regular campus? ☐ Yes ☐ No
If no, please explain: _____

Is there any possibility of the homebound teacher becoming infected by this disease or carrying it to another student if assigned at this time? ☐ Yes ☐ No

Is the student now physically able to do school work with a homebound teacher? ☐ Yes ☐ No

Is the student permitted to participate in any activities outside the home? ☐ Yes ☐ No If yes, explain:
_____

If the student has not been totally confined to the home setting, is the student able to receive any instructional services on a regular campus (e.g. shortened school day)? ☐ Yes ☐ No
Please explain: _____

Are there any accommodations that would enable the student to receive his/her instruction on the regular campus (e.g. special transportation, frequent breaks, rest periods, shortened school day)? ☐ Yes ☐ No

If yes, describe: _____

What medication(s) is the student now taking? _____

What effects, if any, will the medication have on the student's learning (e.g. concentration, attention span, emotional side effects?) _____

If homebound placement is recommended, please check the following:

☐ Yes ☐ No At this time, the student is unable to function in the school setting, even for a shortened week and a shortened day at this time.

☐ Yes ☐ No I recognize that homebound placement is a very restrictive educational placement that prevents the student from interacting with his/her peers.

☐ Yes ☐ No My recommendation concerning educational placement is based on my professional medical assessment of this student's condition.

_____	_____	_____
Licensed Physician's Signature	License #	Date
_____	_____	_____
Physician's Printed Name	Telephone Number	Fax Number

Please return this form to:
FAX: 512-572-8345
Suzanne Gambino - Homebound Teacher
sgambino@bisdtx.org