Section 504 Parent/Guardian Input

School District/Charter School Name: Washington County School District

Student Name:	Date:
Student ID:	Date of Birth:
School:	Grade:
Parent/Guardian Name:	Primary language spoken in home:

I. Contact Information

Primary Contact Name: Relationship: Phone: Email:	**Additional Contact** Name: Relationship: Phone: Email:
Additional Contact Name: Relationship: Phone: Email:	**Additional Contact** Name: Relationship: Phone: Email:

With who does the student live?
Who has legal authority to make educational decisions for this child?

Other Children in the Home

Name	Age	Relationship

Other Adults in the Home

Name	Relationship

II. Family History:

	Yes	No
Has anyone in the family struggled with mathematics, reading, or writing? If so, how was the individual related to the child and what was the difficulty?	◯	◯
Has anyone in your family ever been diagnosed as learning disabled? If so, what is the diagnosis and what is the relationship to your child?	◯	◯
Has anyone in the family ever been diagnosed with Attention Deficit Hyperactivity Disorder? If so, how was the individual related to the child?	◯	◯
Have there been any important changes with the family during the last three years (for example, job changes, moves, divorce or separation, births, deaths, illnesses, etc.)? If so, please describe:	◯	◯

III. The Student at home:

What does your child do when not in school? (Please list the student's common indoor and outdoor activities)

How does your child interact with friends? Is he/she more or less social than the typical child of the same age?

Please describe your child's behavior at home (for example, is he/she generally well behaved? Does he/she get along with family members, neighbors, peers?)

What are some of your child's strengths?

IV. Medical and developmental history:

Doctor's reports, letters and diagnosis can help the Section 504 committee have a more complete picture of your child. If necessary, the district or school may request written consent from you to obtain information directly from your healthcare provider.

Describe any problems associated with your child's birth:

Compared to other children in the family, the child's development was:
Slower ◯ About the same ◯ Faster ◯

	Yes	No
Is your children currently under the care of a healthcare provider for a medical problem? If so, describe the problem?	☐	☐
Is your child currently taking any medications (either prescription or over the counter)?	☐	☐

Name of Medication	**Healthcare Provider Prescribing**	**How long has your child been taking it?**	**Dosage/ Frequency**	**Side Effects**

Does your child have asthma? If so, how is it treated?

Does your child have allergies? If yes, to what:

How frequent are reactions?

What are symptoms of reaction?

How are reactions treated?

When was the last reaction?

	Yes	No	N/A
Has your child ever been critically or chronically ill? If yes, explain.	◯	◯	
Does your child have a condition or illness with symptoms that are sometimes more serious than at other times? If so, what is the name of the condition or illness?	◯	◯	
a. When and how often is the condition or illness a problem for your child?			◯
b. How does the condition or illness affect your child when the symptoms are most serious (are there things that he/she cannot do or are more difficult because of the condition or illness)?			◯
Has your child recovered from a serious medical condition or illness (such as cancer)? If so, what was the condition or illness?	◯	◯	
a. When did your child suffer from this condition or illness? How did the condition or illness affect your child when the symptoms were most serious?			◯
Is this condition or illness likely to return?	◯	◯	
Has your child repeated any grades? If so, which grade(s)?	◯	◯	
Has your child ever been diagnosed with a learning disability? If so, what kind and when?	◯	◯	
Has your child ever mentioned problems in schools? If yes, what?	◯	◯	
Has your child ever experienced a seizure?	◯	◯	
If yes: How frequently to seizures occur? What is/was the duration of the seizures? What assistance is needed if your child experiences a seizure?			◯

V. Behavior Checklist

Please rate the extend that your child exhibits the following characteristics:

N - never, almost never; s - sometimes; F – frequently; A – almost always

	N	S	F	A
Shows good verbal ability? (good conversationalist, storyteller, etc.)				
Understands things read or told to him/her?				
Asks you to repeat words or sentences?				
Displays poor reading skills?				
Fails to understand what he/she reads?				
Has poor spelling?				
Has trouble with mathematics?				
Has difficulty completing tasks?				
Has a poor memory?				
Has poor handwriting skills?				
Shows poor organization skills?				
Daydreams?				
Has a short attention span?				
Acts impulsively?				
Is considered overactive?				
Has trouble following directions?				
Acts in an immature manner?				
Fails to get along with his/her peers?				
Is oppositional with parents/other adults?				
Fails to consider the consequences of behavior?				
Exhibits moodiness or anger?				
Appears hypersensitive? (feelings are hurt easily)				
Is upset when routine is changed?				
Appears sensitive to others' feelings?				
Says he/she does not like school?				

If your child is eligible under Section 504, what services or accommodations do you think are necessary so that your child can participate and benefit from school?