Section 504

Parent Input

NEW Place in Request for support resources if not accessible via Parent Vue? Your suggestions are welcome.

Date: School Grade

Student name and student #: DOB

Parent Name(s): Phone

Address (Information in blue is auto generated in SIS and/or located in student profile)

What is the primary language spoken at home: _____

Has your child ever been retained/repeated a grade? ☐ No ☐ Yes

If yes, which grade: _____

Has your child ever been referred to, or received accommodation or services, under any of the following programs?

☐ No ☐ Yes *

- Title I
- Student Assistance Team
- English Language Learner (ELL)/ Limited Language Proficiency
- Regular School Nursing Services
- School Health Services/Health Plan
- Section 504
- Special Education

If yes*, complete the information below for each referral:

Name of State	Name of District	Name of Campus/School

Health

Do you have any concerns about your child in the following areas? ☐ No ☐ Yes
If yes, check **all areas of concern**:

☐ Caring for self	☐ Speaking	☐ Reading	☐ Walking
☐ Hearing	☐ Seeing	☐ Breathing	☐ Eating
☐ Bending	☐ Standing	☐ Sleeping	☐ Lifting
☐ Learning	☐ Thinking	☐ Concentrating	

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- ☐ Communication
- ☐ Bowel function
- ☐ Circulatory function
- ☐ Digestive Function
- ☐ Brain function
- ☐ Neurological function
- ☐ Respiratory Function
- ☐ Reproductive function
- ☐ Endocrine function
- ☐ Performing manual tasks
- ☐ Normal cell growth
- ☐ Immune system
- ☐ Other - please be specific:

Give a brief description of the concern:

_____

_____

_____

Has your child been diagnosed or identified with any physical or mental impairment related to the identified area(s) of concern or with any other physical or mental impairment?

☐ No ☐ Yes*

If yes*, please provide the following information for each medical provider or other professional providing the diagnosis/identification.

Diagnosis/type of impairment	Name of medical provider or other professional	Address	Is there an evaluation report? If so please provide the date of the report and copy of the report if available.
1.			
2.			
3.			
4.			

Medications and/or procedures administered at school:

Does your child take medication? ☐ No ☐ Yes

If yes, please provide the following information for each medication/procedure administered for your child:

Medication/Procedure	Frequency/Schedule
1.	
2.	
3.	
4.	

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*If you checked “Yes” to question marked with an *, you are requested to provide a Consent for Release of Information for each school, medical provider, or other professional so that the District can obtain information that will help the 504 Committee determine your child’s needs.

Vision
Date of last vision screening/test:

Does your child have any vision difficulties? ☐ No ☐ Yes

If yes, please check all that apply:

☐ My child has prescription glasses or contacts.

☐ My child has vision problems that are not correctable with prescription glasses/contact lenses.

If your child has vision difficulties that are not correctable with prescription glasses/contact lenses, describe the difficulty and provide the name of the medical provider that diagnosed the difficulty.

_____

_____

Diagnosed by: Phone:
Address:

Hearing
Date of last hearing screening/test:

Does your child have hearing difficulties? ☐ No ☐ Yes

If yes, please check all that apply:

☐ My child has hearing aids.

☐ My child has hearing difficulties that are not correctable with hearing aids.

If your child has hearing difficulties describe the difficulty and provide the name of the medical provider that diagnosed the difficulty.

_____

_____

Diagnosed by: Phone:
Address:

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_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian printed name