

Parent Input for Section 504 Evaluation/Review of Existing Data

The information requested will greatly assist the §504 Committee in decisions that will be made regarding your child. If you have additional information which you want the Committee to consider (and that is not requested here) please feel free to attach additional pages. Disregard any question that makes you uncomfortable. If you would prefer to provide this information by phone, please contact

_____ at _____.

Student's Name: _____ DOB: _____

School: _____ Grade: _____ Phone: _____

Address: _____

GENERAL INFORMATION

Name of Father _____ Occupation _____

Name of Mother _____ Occupation _____

YES NO Do both parents live in the student's home? If not, with whom does the student live?

Name _____ Relationship _____

Education Level: Father _____ Mother _____

OTHER CHILDREN IN THE HOME **Please use the back of this sheet if more space is needed.

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YES NO Do any of these children have learning problems? If yes, specify:

OTHER ADULTS IN THE HOME **Please use the back side of this sheet if more space is needed.

Name	Relationship
_____	_____
_____	_____
_____	_____

YES NO Have any other family members had learning problems? If yes, please specify:

The primary language spoken at home is _____.

How long has the student lived in the United States? _____

What time does the student go to bed at night? _____ Does the student eat breakfast? _____

EDUCATIONAL EXPERIENCE AT HOME

Please circle those items available at home:

Television Books Tape Recorder Educational Toys Record Player or Stereo Radio Computer

What activities do the family participate in together? (read, watch television, go camping, etc.)

Have there been any important changes within the family during the last three years? (For example: job changes, moves, births, deaths, illnesses, separations, divorce)

With whom in the family is the student particularly close? _____

YES NO Has the student ever been separated from the family due to family problems, health reasons, etc.?

If YES, for what reason? _____

How did the student react to the separation? _____

Describe the student's behavior at home with peers, siblings, neighbors, parents. (For example: is he/she generally well-behaved, passive or aggressive, social or a loner, affectionate or withdrawn, etc.)

What methods of discipline are used with this student at home? (For example: spanking, extra chores, early bedtimes, taking away privileges; is he/she given rewards for good behavior?)

What is your child's reaction to discipline? _____

Who is the main disciplinarian? _____

PEER RELATIONSHIPS

Does the student prefer to play/socialize with boys or girls? _____

Does the student have friends? his/her own age? YES NO

younger? YES NO

older? YES NO

What does the student do when not in school? (watch television, read, part-time job, play with other children)

Indoors: _____

Outdoors: _____

Has your child mentioned problems with school? How does he/she feel about the problem? _____

YES NO Do you think that the student has a problem in school? If yes, what? _____

YES NO If you think that the student has a problem in school, have you shared those concerns with school?

When did you first notice the problem? _____

When did you share your concerns? _____

With whom did you share your concerns? _____

What do you think is causing the problem? _____

YES NO Does your child have a part-time job after school or on the weekends? If yes, please specify.

CHILDHOOD HISTORY

Does your child have or has he/she had any of the following:	YES	NO	Began at age	Stopped at age	Still has problem
Frequent fevers					
Frequent earaches					
Frequent vomiting					
Thumb sucking					
Nightmares					
Sleepwalking					
Head banging					
Rocking of body					
Teeth grinding					
Bedwetting					
Fingernail biting					
Temper tantrums					
Has run away from home					
Ever lost consciousness					
Ever had convulsions					

Doctor's reports, letters and diagnoses can be very helpful to the 504 committee. Please attach those medical records so that the Committee can have a more complete picture of your child. If you would prefer, you may give the District written consent to see those records from the doctors' directly. Please notify

_____, Coordinator, at _____ to get the necessary form.

YES NO Is your child under the care of a physician for a medical problem? If yes, describe the problem.

YES NO Does your child appear to have any other physical health problems, including allergies? If yes, Please explain. _____

YES NO Is your child now taking any medications? If yes, please explain. _____

YES NO Do you know of any side effects the medicine might have? If yes, please explain. _____

YES NO Has your child ever taken medicine for a long period of time? If yes, please explain. _____

YES NO Has your child ever been hospitalized? If yes, please state why and for how long. _____

YES NO Does the child appear to be very different from your other children, in his/her behavior, learning skills, or other skills? If yes, how?

Compared to the other children in the family, this child's development was:

_____ Slower _____ About the same _____ Faster

At what age (in months) was student able to do the following?

Sat without support _____ Crawled _____ Walked without support _____

Used spoon fairly well _____ Reasonably well toilet trained _____

If the student qualifies for special services, what service do you think would best help your son/daughter?

Signature of Parent

Date

Signature and Position of person completing section

Date