**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

What is the primary language spoken in the home? Click or tap here to enter text.

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

If Yes, what grade? Click or tap here to enter text.

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

No  Yes\*

* Title One services
* Student Assistance Team
* English Language Learner (ELL)/ Limited English 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 |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Do you have any concerns about your child in the following areas?  No  Yes

If Yes, check **all areas of concern**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Caring for self | Hearing | Bending | Digestive function | Respiratory function |
| Performing manual tasks | Speaking | Reading | Normal cell growth | Circulatory function |
| Walking | Breathing | Concentrating | Bowel function | Endocrine function |
| Seeing | Learning | Thinking | Neurological function |  |
| Communicating | Eating | Sleeping | Brain function |  |
| Standing | Lifting | Immune system | Reproductive function |  |
| Other – be specific: Click or tap here to enter text. | | | | |

Give a brief description of the concern(s): Click or tap here to enter text.

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\*, provide the following information for each physician or other professional providing the diagnosis/ identification:

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis/Type of Impairment | Name of doctor or other professional | Address of doctor or other professional | Is there an evaluation report? If so, provide the date of the report and attach a copy of the report, if available to you. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Date of last vision screening/ test: Click or tap here to enter text.

Does your child have any vision difficulties?  No  Yes

If Yes, please check all that apply:

My child has prescription glasses or contact lenses

My child has vision difficulties that are not correctable with prescription glasses or contact lenses

If your child has vision difficulties that are not correctable with prescription glasses or contact lenses, describe the difficulty and provide the name of the doctor that diagnosed the difficulty:

Click or tap here to enter text.

Diagnosed by: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Date of last hearing screening/ test: Click or tap here to enter text.

Does your child have any hearing difficulties?  No  Yes

If so, 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 doctor that diagnosed the difficulty:

Click or tap here to enter text.

Diagnosed by: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Does your child take medication?  No  Yes \*

If yes, provide the following information for each medication taken by your child:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Frequency |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Parent/Guardian Signature Date

Click or tap here to enter text.

Parent/Guardian Printed Name