

Section 504 Parent Input Form



Name:

Date of Birth:

School:

Age:

Date of Plan:

Grade:

1. **Medical Diagnosis for Section 504 Disability(s)** Please attach any medical documentation, psychological evaluations or other information which you would like the 504 team to consider and which you believe supports the student having a physical or mental impairment which substantially limits one or more major life functions.):
2. **When and how often is the condition or illness a problem for your child?:**
3. **In what way do you feel your child's medical diagnosis is impacting them in school?:**
4. **Has your child talked to you about difficulties or problems at school? Please explain.**
5. **What accommodations do you feel are necessary so that your child can benefit from school?**
6. **Please list all medication currently taken :**
7. **Please describe any side effects the student experiences from these medications:**
8. **Have there been any important family changes during the last three years (for example, moves, births, deaths, illnesses, separations, divorces):**
9. **Are you working with any other agencies?**

Parent Signature: _____ Date: _____