*APPENDIX E*

##### Optional Parent Questionnaire

Student       Date of Birth

Address      Grade

Parent/Guardian       Phone

School

1. Please share your thoughts on any specific disability/problems/concerns that you have regarding your child.
2. Describe the symptoms and where they occur and under what circumstances? (i.e., at home, relatives,

neighborhood, school, when asked to complete a task, when trying something new, etc.)

1. Explain how the disability/concern limits your student’s ability to access the educational program or a major life activity.
2. What accommodations have been tried with success or lack thereof by you, by other child providers, other schools, etc.
3. Optional: Provide available medical information including a written diagnostic statement and copies of any/all reports you would like the District to consider.
4. Has medication been recommended?  Yes  No

Name of Medication

When started

Dosage

Time(s) given

Physician

1. What are your recommendations for consideration at an upcoming conference?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Signature

This document may be shared with appropriate school personnel such as Principal, School nurse, counselor, teachers, and building Coordinator of Section 504.

Return to      , Building Coordinator of Section 504.