*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.