Save

SCHOOL CENTER DISTRICT

# 504 PARENT INFORMATION/STUDENT HISTORY FORM

| | | | | | |
|---|---|---|---|---|---|
| Student: | | Grade: | | Date: | |
| School: | | Date of Birth: | | | |
| Form Completed by: | | Relationship: | | | |
| Address: | | | | | |
| Email: | | Phone: | | | |

Has the student ever been evaluated under IDEA for special education? ☐ No ☐ Yes

**MEDICAL HISTORY**

Name of Doctor/Provider:

Has the student ever been hospitalized? ☐ No ☐ Yes If Yes, when?

Reason:

Has the student had any of the following surgeries?

☐ Ear Tubes ☐ Eye Surgery ☐ Tonsillectomy ☐ Adenoidectomy

☐ Other: When?

Has the student had any significant accidents or injuries? ☐ No ☐ Yes If Yes, please explain:

Has the student had any significant illnesses? ☐ No ☐ Yes If Yes, please explain:

Does the student have a current chronic condition/disorder diagnosis? ☐ No ☐ Yes

☐ ADHD/ADD ☐ Diabetes ☐ Anxiety ☐ Seizures ☐ Mood Disorder
☐ Depression ☐ Bipolar ☐ Heart Condition ☐ Chronic Ear Infections

Save

SCHOOL CENTER DISTRICT

# 504 PARENT INFORMATION/STUDENT HISTORY FORM

**Page 2**

Is the student currently taking medication? ☐ No ☐ Yes If Yes, name and purpose:

Does the student experience any side effects? ☐ N/A ☐ No ☐ Yes If Yes, please explain:

Does the student wear glasses? ☐ No ☐ Yes If Yes, date of last exam:

Does the student wear hearing aids? ☐ No ☐ Yes If Yes, date of last exam:

Is the student receiving services outside of school? ☐ N/A ☐ No ☐ Yes

☐ Counseling ☐ Tutoring ☐ Physical Therapy ☐ Speech Therapy

☐ Occupational Therapy ☐ Other:

If Yes, reason:

Please share what mental or physical impairment your student has that "substantially" limits his/her abilities in the educational environment:

When did these concerns begin?

How do you feel the student compares to others his/her age?

What accommodations do you feel will help your student?

**Please return to: _____ By: _____**