Independent School District 15
4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

# Section 504 Parent/Guardian Input/Verification of Consent

| Student name: | | Student ID: | Date: |
|---|---|---|---|
| Name of person completing form: | Parent/guardian email: | | Primary phone: |

**Background questions**

What are some of your student's strengths?

What are your concerns for your student at school and when did they first begin?

What do you think is causing the problem?

Has your student mentioned any concerns with school? If so, how does he/she feel about it?

**Health history**

What is your student's physical or mental health diagnosis? Please attach documentation from a licensed professional.

Please describe any serious illnesses, accidents, or hospitalizations the school should know about.

Is your student receiving outside service(s) from another agency? *Check all that apply.*

- ☐ OT/PT/Speech
- ☐ Medical Therapy
- ☐ Mental Health Services
- ☐ Chemical Health Services
- ☐ County Services
- ☐ Rehabilitation Services
- ☐ Probation Office
- ☐ Other

Is your student currently taking medications related to your concerns? *If so, please list.*

Please tell us anything else that you think would be helpful in planning for your student's success at school.

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**Verification of Consent**

- ☐ I consent to the initial Section 504 evaluation of my student and the 504 process which, if applicable, includes implementation of a Section 504 Accommodcation plan.
- ☐ I do not consent to the initial Section 504 evaluation of my student.

**By signing, I also agree that I have received Section 504 Notice of Student and Parent Rights.**

Parent/guardian signature required: _____ Date: _____