Modification Information Form

Name: ____ Date Completed:__________________________

Programs: ____ Age: _______ Grade: ______

Person filing out form: _____________________________ Relationship to child: ____________________

Home Phone: ________________ Work Phone: __________________ Cell Phone: ___________________

The following questions are for assessment purposes and may be used to assist staff in determining modifications, as stated by the ADA. Modifications will be made on a case by case basis. Please provide as much information as possible so we can better meet your needs. If at any time there are changes to this information, please contact the main office to arrange for changes on the form.

This information is voluntary and is not confidential.

Please check all that apply and explain if applicable

Diagnosis

□ Primary Diagnosis ____

□ Secondary Diagnosis ____

Medications **Please check all that apply and explain if applicable**

□ Medication 1. ____________ 2. ____________ 3. ____________ 4. ______________

Dosage _____________ ____________ ____________ ______________

Frequency _____________ ____________ ____________ ______________

□ Does not take medications

Physical **Please check all that apply and explain if applicable**

□ Walks Independently ____

□ Walks with assistive devise ____

□ AFO or Brace ____

□ Crutches or Walker ______________________________

□ Other ______________________________

□ Manual Wheelchair ______________________________

□ Electric Wheelchair ______________________________

□ Transfers to/from wheelchair independently ______________________________

Daily Living Skills **Please check all that apply and explain if applicable**

□ Toilets independently ______________________________

□ Eats independently ______________________________

□ Understands safety issues ______________________________

□ Other ______________________________

Social Interactions with Peers **Please check all that apply and explain if applicable**

□ Age Appropriate ______________________________

□ Shy or withdrawn ______________________________

□ Aggressive ______________________________

Miscellaneous Conditions **Please check all that apply and explain if applicable**

□ Allergy ______________________________

□ Seizure ______________________________

□ Phobias or Fears ______________________________

(Example: Afraid of water)

□ Glasses or Contacts ______________________________

□ Hearing aids ______________________________

□ Other ______________________________

Behavioral Issues **Please check all that apply and explain if applicable**

□ Age Appropriate ______________________________

□ Behavioral Plan or IEP ______________________________

□ Self Injures ______________________________

□ Aggressive ______________________________

□ Defiant ______________________________

Communication Skills **Please check all that apply and explain if applicable**

□ Verbally Independent ______________________________

□ Speech Impairment ____

□ Communication Aid ____

□ Sign-Language or Gestures ____

□ Non-Verbal ____

Cognitive Skills **Please check all that apply and explain if applicable**

□ Able to follow directions ____

□ Occasionally follows directions ____

□ Unable to follow directions ____

Circle the following activities your child would enjoy participating in.

Games	Outdoor Activities	Reading
Arts and Crafts	Swimming	Field Trips
Music	Playground	Other: _______________

Describe the modifications you are requesting, and any additional information you feel would assist staff in providing a successful experience for your child.

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Date Received: ______________ Date sent to Inclusion Office: ________________ Staff Initials: __________

Follow up information:

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Date of follow up: ____________________ Staff Initials: ____________