



REFERRAL FOR SECTION 504 EVALUATION

This Form is to be completed by the school personnel, parent, or other individual referring the student for an evaluation to determine the student's eligibility under Section 504 of the Rehabilitation Act of 1973. The individual completing this form should provide the requested information to the best of his or her ability. Additional pages may be added to this form if needed. Any questions regarding the completion of this Form should be directed to the designated Section 504 Facilitator.

Date: __/__/____ Person Making this Referral: _____
Relation to Student: _____

STUDENT INFORMATION

Student's Complete Legal Name: _____ DOB: __/__/____
FIRST MIDDLE LAST
School: _____ Grade/Grad Year: _____

PARENT/GUARDIAN CONTACT INFORMATION

Parent or Legal Guardian Name: _____
FIRST MIDDLE LAST

Please indicate preferred method of contact:

- ☐ Email Address: _____
☐ Mobile Number: _____
☐ Other: _____

Primary language of the home: _____

EXPLANATION OF ELIGIBILITY

For a student to be eligible for Protection under Section 504, the student must have a physical or mental impairment that substantially limits one or more major life activities (including but not limited to: walking, seeing, hearing, speaking, breathing, learning, working, caring for one's self, and/or performing manual tasks).

Has this student been diagnosed with a mental or physical impairment? Yes No

If Yes, please list the impairment(s): _____

Please indicate status of official medical documentation:

Official medical documentation* is included with this Referral
Please request official medical documentation* on behalf of this student
A signed Release is included with this Referral
Official medical documentation* is not available

*Official medical documentation includes the diagnosis, the name of the professional making the diagnosis, the initial date of diagnosis, and if applicable, the date the diagnosis was last confirmed. Official medical information is typically provided on clinician/clinic letterhead. Additional supporting documentation, including the tests/tools used to arrive at the diagnosis, and/or clinical observations, can be helpful to the evaluation process and may also be included with this Referral.

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PRESENTING CONCERNS

What are your main concerns with this child's school performance?

What interventions have worked well for this child in the past?

What additional supports do you feel are needed for this child at school?

Please list any service providers involved in this child's care and the length of time of the service (i.e. tutors, therapies, ADHD coaching, etc.).

Upon Completion, please return this form to the "504 Facilitator" at the child's school.

I have reviewed the Notice of Procedural Safeguards and am aware of Parent/Student Rights in Identification, Evaluation, and Placement of Individuals with Disabilities

Signature of Person Initiating Referral

Date

Received by

Date