ROBBINSDALE
Area Schools
Individual focus. Infinite potential.

REFERRAL FOR SECTION 5O4 EVALUATION
Form 504-2

Student Name: _____ DOB: _____

School: _____ Grade: _____

Name of parent(s)/guardian(s): _____

Parent/guardian address: _____

_____

Email Address: _____

Phone Numbers: Home: _____ ☐ *Preferred contact number*

Work: _____ ☐ *Preferred contact number*

Cell: _____ ☐ *Preferred contact number*

Primary language of the home: _____

I. **Explanation of Eligibility:** For a student to be eligible for a Section 504 Plan, the student must have a physical or mental impairment that substantially limits one or more major life activities. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for one's self, and/or performing manual tasks.

II. **Nature of the Concern:** If you believe that a student may be eligible under Section 504, please complete and sign this form, giving specific details about why you are requesting a Section 504 evaluation, and submit it along with supporting documentation to the District's Section 504 Coordinator.

A. Describe the physical or mental impairment which may be substantially limiting a major life activity.

_____
_____
_____
_____
_____
_____

B. Indicate which major life activity(s) is being substantially limited.

[ ] Bending	[ ] Hearing	[ ] Seeing	[ ] Walking
[ ] Caring for One's Self	[ ] Learning	[ ] Sleeping	[ ] Other: _____
[ ] Communicating	[ ] Lifting	[ ] Speaking	[ ]
[ ] Concentrating	[ ] Performing Manual Tasks	[ ] Standing	[ ]
[ ] Eating	[ ] Reading	[ ] Thinking	[ ]

Major life activities also include the operation of a major bodily function. Please check which, if any, of the functions of the following major life activities are or may be impacted by the impairment(s).

[ ] Bladder	[ ] Circulatory	[ ] Immune System	[ ] Reproductive
[ ] Bowel	[ ] Digestive	[ ] Neurological	[ ] Other: _____
[ ] Brain	[ ] Endocrine	[ ] Normal Cell Growth	[ ]

C. Please describe the student's educational concern and how it matches the above criteria. (Identify how it substantially limits a major life activity or activities.)

_____
_____
_____
_____
_____
_____

D. Attach any supporting medical documentation.

By:

_____ _____
Signature of the Person Making Referral **Date of Referral (mo./day/yr.)**

Relation to Student: _____

The signature of the Section 504 Coordinator receiving this referral also documents that the *Notice of Procedural Safeguards Under (Form 504-1)*, and a copy of this referral have been given or sent to the parent/legal guardian.

_____ _____
Date Received (mo./day/yr.) **Signature of the Section 504 Coordinator**