Highline Public Schools
Section 504 Referral Form

Student's Name: Date:
School: Birthdate:
School Year: Grade:

Any person, student, parent or guardian who believes a student has a disability that could affect their education, and who believes the impact of the disability might be alleviated by some services, modifications, and/or accommodations may refer the student for consideration for a Section 504 evaluation.

For a student to be eligible for Section 504 services, the student must have a physical, mental, or behavioral disability that substantially limits one or more major life activity.

1. **Do you suspect a disability?** ☐ Yes ☐ No **If yes, for what?**

☐ ADHD or ADD	☐ Emotional/Mental Illness	☐ Orthopedic Impairment
☐ Allergies	☐ Heart Disease	☐ Vision Impairment
☐ Cancer	☐ Hearing Loss	☐ Other: ______________________
☐ Drugs or Alcohol	☐ Immune System Impaired	☐ Other: ______________________

2. **What major life activity do you believe the disability is substantially limiting?**

☐ Learning	☐ Eating	☐ Thinking/Concentrating
☐ Walking	☐ Breathing	☐ Communicating
☐ Seeing	☐ Sleeping	☐ Other: ______________________
☐ Hearing	☐ Speaking	☐ Other: ______________________

3. **Describe your concern? (e.g. what the student is not able to do or benefit from because of their impairment).**

4. **What has been done so far to address the student's impairment? Has the intervention helped?**

Referred by: ☐ Parent ☐ District Employee
Signature: Telephone:
Please return form to: Telephone:

504 DESIGNEE USE ONLY		
Date Received:	Parent Notified Date: ☐ Phone ☐ Letter	