

OAK PARK AND RIVER FOREST HIGH SCHOOL

201 NORTH SCOVILLE AVENUE • OAK PARK, IL 60302-2296

SECTION 504 PLAN REFERRAL

Student Information:

Student Name _____ Birth Date _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Parent(s) Name(s) _____ Home Phone _____ Work Phone _____
504 Coordinator/Responsible Staff Member _____ Phone _____

Referral:

Any person who feels a student needs accommodations for a disability must complete this request form and submit any relevant documentation supporting that need to **the student's school counselor**.

1. Is the student suspected of having a physical or mental impairment which substantially limits one or more major life activities? Or, does the student have a record of such impairment? Or, is the student regarded as having such an impairment? ☐ Yes ☐ No

2. If yes, describe the nature of the impairment. _____

3. If yes, which major life activity is limited? (check one or more as appropriate)

- | | | |
|---|------------------------------------|--|
| ☐ caring for self | ☐ sleeping | ☐ communicating |
| ☐ hearing | ☐ bending | ☐ performing manual tasks |
| ☐ eating | ☐ thinking | ☐ major bodily function (i.e. immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions) |
| ☐ lifting | ☐ working | |
| ☐ concentrating | ☐ seeing | |
| ☐ learning | ☐ breathing | |
| ☐ walking | ☐ standing | |
| ☐ speaking | ☐ reading | |
| ☐ other (DESCRIBE) _____ | | |

4. Describe how the impairment affects each major life activity checked above. _____

5. Does the student have a current medical diagnosis? ☐ Yes ☐ No ☐ Don't know
If yes, list here: _____

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6. Do you have any documentation (e.g., medical diagnoses or other information from a physician) that supports your request. ☐ Yes ☐ No

If yes, please provide copies of relevant documentation with this form. If possible, please provide information that is no more than three years old and, in the case of a medical diagnoses, that is no more than one year old. This information will assist our team in reviewing the request for an evaluation.

7. What interventions and/or strategies have been attempted in the past to help your student to be more successful at school and home?

8. What are the biggest concerns you have for your student?

9. Describe what accommodations (if any) you believe your student would need to access the educational program in a manner similar to non-disabled peers:

Note: Upon receipt of this referral, the District's Pupil Support Service Team (comprised of three Counselors, a School Social Worker, a Student Dean, a School Psychologist/504 Coordinator and the Assistant Principal for Student Services) will meet to review relevant information about the student in order to determine whether a 504 evaluation is deemed necessary. In making the determination as to whether a 504 evaluation is warranted, the Pupil Support Service Team will review the student's educational data, standardized test scores, any outside reports shared by the parent/guardian, teacher input based on current classroom performance, and any other relevant information provided to the Pupil Support Service Team.

Please circle below the best means of communication to share information regarding the screening committee's decision. Include parent(s) name and preference.

Contact: _____ Telephone or Email: _____

Contact: _____ Telephone or Email: _____

Printed Name: _____ Signature: _____

Relationship to Student: _____ Date: _____