

Falmouth School Department
SECTION 504 REFERRAL FORM

Student's Name: _____	DOB: _____
School: _____	Grade: _____
Teacher: _____	
Counselor: _____	

1a. Person who is making this referral:

1b. Are you the student's parent/guardian? YES NO

- If NO, has the parent been informed? YES NO

2a. Briefly describe the areas of concern for this student:

2b. Briefly describe any attempts to address these concerns:

3a. Has this student ever been referred or identified for special education or Section 504 services previously?

YES NO Do Not Know

3b. If YES, please describe any decisions reached about the student's eligibility or placement, to the extent known:

4. Please list and attach any supporting documentation (including diagnostic, testing, reports, etc.) or other information that may be useful in processing this referral:

5. Suspected Disability:

Person Completing Form

Title

Date

Signature of Building 504 Coordinator

Date Received