



Section 504 Student Referral

(Information about the student, to be considered when determining whether the student is eligible under Section 504 and, if eligible, what accommodations, related aids, or services the student needs.)

School: A. Smith Elementary McClure Elementary H.T Elementary GMS GHS

Name of Student: _____ Grade: _____

Age: _____ Birth Date: _____ Sex (check one) Male Female

Parent/Guardian Name: _____ Parent/Guardian Name: _____
Mother/Guardian Name Father/Guardian Name

Parent Address: _____

Phone: _____ Cell: _____

Surrogate Needed? Yes No Name: _____

Sign Language/Interpreter Needed? Yes No Home Language: _____

Parents prefer written communications in: English Spanish Other: _____

Referred by: _____ Date of referral: _____

School: _____ Teacher: _____

Describe why you are referring this student for a Section 504 evaluation:

What mental or physical impairment(s) do you believe this student has? Please describe the condition(s) and/or list information confirming the condition(s).

Please describe how you think this mental or physical impairment is impacting this student.



What things do you think are needed to assist this student in being able to benefit from his or her educational experience because of a mental or physical impairment?

What services or accommodations do you think would help improve or eliminate your child's difficulties?

Does the student receive any support or services outside of school? Yes No

If yes, please explain:

Medical Information: (A formal medical diagnosis is not required for Section 504 referral or eligibility.)

Does the student have any formal medical diagnoses? Yes No

If yes:

Diagnosis: _____ Diagnosed by: _____ Date: _____

Diagnosis: _____ Diagnosed by: _____ Date: _____

Is the student on any medications? Yes (list) _____ No

If yes, what is the positive or negative impact of those medications on the student?

****Please attach all supporting documentation (medical records, letters, evaluations, etc.)

Parent Consent (Only required for initial evaluation and initial placement.)

- Yes, I do consent to an initial evaluation for my child.
No, I do not consent to an initial evaluation for my child.
Yes, I do consent for initial placement for my child for a Section 504 plan.
No, I do not consent for initial placement for my child for a Section 504 plan.

Signature: _____ Date: _____



TO BE COMPLETED BY THE SECTION 504 TEAM

PRE-REFERRAL MEETING:

Date of pre-referral with the parent: _____

What was the outcome of this meeting? _____

Was this a person-to-person conference or telephone conference? Person-to-person Telephone

Name of Person who conducted the conference: _____

Date Referral was received: _____

Type of referral: Initial Re-evaluation Other

Have the parents/guardians been contacted regarding the student’s learning/behavior difficulties? Yes No

If yes, list their efforts to assist in the remediation of the difficulties:

SCHOOL DISTRICT DECISION REGARDING WHETHER OR NOT TO EVALUATE

After reviewing this referral, the following decision has been made by the School District:

Recommendations

- Refer for Comprehensive Evaluation under IDEA
- Screen by ESL
- Screen/evaluate for Section 504 eligibility
- Other, Specify _____

Signature: _____ **Date:** _____
(504 Building Coordinator)