Half Hollow Hills Central School District

504 PARENT REFERRAL FORM

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

Counselor/Psychologist: _____

Parent(s) Name: _____ Phone Number:_____

Address: _____

_____

1. Describe the nature of the disability and how it affects your child's current academic program.

2. Describe how the student's disability affects a major life activity (such as hearing, walking, seeing, speaking, breathing, learning or working).

3. Please list any prior evaluations conducted. You may attach supporting documentation (i.e.- medical diagnosis), but you are not required to do so.

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4. What, if any, specific modifications are you seeking?

Any additional documentation you can provide, such as a medical diagnosis or evaluation, is encouraged but not required.

Please return this form to your child's building principal or the 504 Compliance Officer.

Please sign and date:

Name of Parent _____

Signature of Parent _____

Date _____