PEMBERTON TOWNSHIP SCHOOLS
You can get there from here!

KIMBERLY FERLAUTO
Director of School Counseling/Health Services

JEFFREY HAVERS
Superintendent
ADELINA GIANNETTI
Assistant Superintendent

504 Parent Referral Form

Student's Name: _____ Date of Birth: _____

School: _____ Grade: Counselor: _____

Parent(s) Name: _____ Phone Number: _____

Address: _____

I. Describe the nature of the handicap and how your child's current academic program discriminates against them.

_____
_____
_____

II. Describe how the student's handicap affects a major life activity (such as walking, seeing, speaking, breathing, learning or working). Please attach any supporting documentation.

_____
_____
_____

III. What, if any, specific accommodation/modifications are you seeking?

_____
_____
_____

In order to assist our committee in properly evaluating your request, we ask that you return this form with a professional evaluation to your child's guidance counselor.

1. Professional's Name: _____ Phone: _____

_____

OR

2. Doctor's Name: _____ Phone: _____

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