



Union County Vocational - Technical Schools

Office of Student Services

1776 Raritan Road, Scotch Plains, NJ 07076

908-889-8288 Ext 339 Fax 908-889-1599

504 Referral Form

Student Name:

Today's Date:

Student's Date of Birth:

Student's School:

Name of Person Making Referral:

Relationship to Student:

☐ Parent/Guardian

☐ UCVTS Staff

Does the student have a known disability? ☐ Yes ☐ No If yes, please explain & attach the medical documentation.

Does this student receive any support or services outside of school? ☐ Yes ☐ No If yes, please explain.

Please list your child's current and past medications (excluding antibiotics)

Please check areas of concern that affect your student's ability to access the educational program:

☐ Ability to focus on task	☐ Fine Motor Skills	☐ Movement
☐ Ability to follow directions	☐ Frustration/Gives up easily	☐ Organization Skills
☐ Ability to stay on task	☐ Gross motor skills/coordination/mobility	☐ Personal responsibility
☐ Articulation/Speech	☐ Hearing ability	☐ Relationships with adults
☐ Attendance	☐ Language skills	☐ Relationships with peers
☐ Communication	☐ Listening Skills	☐ Social Skills
☐ Disengaged from education	☐ Memory/Retention	☐ Vision
☐ Others		

Please list any major factors and/or changes to the environment and/or family structure that may have affected the student (i.e death/loss, moving schools/neighborhood, illness, etc.)



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Has this student previously been evaluated for a 504 Plan: ☐ Yes ☐ No

If yes please explain & provide a copy:

Has this student received special education services? ☐ Yes ☐ No If yes, please explain & provide a copy of plan:

Has a professional formally diagnosed the student with a mental or behavioral disorder? ☐ Yes ☐ No If yes, please list the diagnosis;

Has this student been screened through the Mental Health Crisis? ☐ Yes ☐ No

Please provide any additional information you have related to this student that would help the 504 Team determine what accommodations or related services may be necessary.

504 Coordinator Name: _____

Date of Referral: _____

Date Completed: _____

Counselor,

Please provide a copy of:

1. Standardized Scores
2. Transcripts
3. Prior Instructions
4. Attendance
5. Screening History



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Information and Procedures For Disability and Accommodations Section 504 of the Rehabilitation Act of 1973

Dear Parent/Guardian,

The School has developed the following procedure to ensure that an otherwise qualified student with a disability receives reasonable and sufficient accommodations to allow him or her to access her or his educational curriculum. To accomplish this, the school requires that the attached forms be reviewed, complete, and submitted to the school Section 504 committee.

Section 504 of the Rehabilitation Act of 1973 defines an individual with a disability as;

Any person who (i) has a *physical or mental impairment* which substantially limits one or more major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment.

A *physical or mental impairment* means (A) has a physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems; neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitourinary; hemic and lymphatic; skin and endocrine; or (B) any mental or psychological disorder, Such as mental retardation, organic brain syndrome emotional or mental illness and specific learning disabilities.

Major Life Activities means functions such as caring for one's self, performing manual tasks walking, seeing, hearing, speaking, breathing, learning, working, eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, and communicating. Major life activities can also include major bodily functions such as immune system function, bowel function, neurological function, circulatory function, normal cell growth, bladder function, respiratory functions, endocrine function, digestive function, brain function, and reproductive function.

Thank you for your care and diligence in providing the school with the information required to develop an accurate understanding of the student's disability and in assisting the school in developing a program of accommodations, as appropriate, to assist his/her in gaining from an education.



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Consent for Release of Information Section 504 Eligibility

Student Name _____ Date of Birth _____

Student Number _____ School _____

Regarding the student identified above, I authorize my child's treatment provider, whose contact information is listed below, to furnish written information and/or telephone communication relating to my child's medical condition and functioning to appropriate school staff. I understand that the appropriate school personnel will also provide input to the physician named above.

Diagnosing Professional's Name _____

Diagnosing Professional's Telephone _____

Diagnosing Professional Fax Number _____

Diagnosing Professional Address _____

Parent/Guardian Name (Type or Print)

Parent/Guardian Phone

Parent/Guardian Signature

Date



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Diagnosing Professional Guidelines 504 Eligibility Considerations

In order to assist in students' success, the school requires your assistance in providing your expertise in sharing diagnostic information. This information will assist the school team in determining what support might be required for this student's achievement in high school.

1. The purpose of certification of a diagnosed or medical disorder is to provide professional documentation that a student has a disability/condition that may require accommodations or special considerations in the school setting.
2. The principal/school counselor/school psychologist may contact the Diagnosing Professional in order to confirm or clarify information. Therefore, parents are asked to authorize a release of information so that the diagnosis professional and school staff may share information related to the diagnosis.
3. The school team from the student's **home school** will use the referral information along with other information as needed to determine necessary support.
4. Having a 504 accommodation plan on file or an IEP provides the necessary individual support for a student to have equal opportunity for success. It does not guarantee passing grades and does not constitute an automatic reason to earn "incomplete" at the end of a grading period. the student must successfully complete coursework and assessments in order to receive course credits.

Parent/Guardian Signature

Date

Diagnosing Professional Signature

Date:



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Certification of Diagnosis with Educational Implications

A licensed or certified professional must complete this form.

Student Name

Date of Birth

Parent/Guardian

Student Diagnosis: _____

Presently Prescribed Treatment: _____

Prognosis: _____

Date of initial consultation for this condition: _____

1. In your opinion, does the condition/diagnosis limit one or more major life activities?
Yes or No
2. Provide a description of the physical or mental impairment that substantially limits a major life activity
(e.g. walking, breathing, learning, working, hearing, speaking, caring for oneself)

3. Is the student currently taking medication for the disability? Yes or No
4. Do you anticipate the student may miss more than 10 school days per semester attributed to this disorder?
5. List physical limitations affecting physical education activities:

I hereby certify this student has the diagnosed disorder listed above.

Name (Type or Print)

License Title

Diagnosing Professional Signature

Phone Number

Date



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SECTION 504 - NOTICE OF PARENTAL RIGHTS

The following rights are granted by Federal law to students with disabilities. The intent of the law is to keep you, the parent, fully informed concerning decisions about your child and to inform you of your rights. You have a right:

- To have your child take part in, and receive benefits from, public education programs or activities without discrimination based on his/her disability;
- To have the school district advise you of your rights under Federal law;
- To receive notice with respect to the identification and evaluation of your child and the determination if your child is a qualified individual requiring accommodations necessary to provide access to educational programs and activities;
- To have your child receive a free appropriate public education in the least restrictive environment;
- To have your child receive services and be educated in facilities comparable to those provided to nondisabled students.
- To have evaluation, educational, and placement decisions made based on a variety of information sources, and by persons who know your child and who are knowledgeable about the evaluation data and placement options;
- To have your child be given an equal opportunity to participate in nonacademic and extracurricular activities offered by the district;
- To have the opportunity to review relevant educational records under the Family Education Rights and Privacy Act (FERPA);
- To file a local grievance with your school if you feel your child is being discriminated against because of their disability by contacting Laura Reigelsperger, 504 ADA Compliance Officer;
- To request a hearing before an impartial hearing officer by notifying the school principal should you disagree with the decisions reached by school/district personnel for accommodations for access to educational programming and/or facilities;
- To file a formal complaint with the regional Office for Civil Rights. The office is part of the U.S. Department of Education. The headquarters office is located at U.S. Department of Health & Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201

☐ I acknowledge receipt of Notice of Parental Rights.

Parent Signature: _____



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Section 504/ADA Parental Notification and Consent

As a part of our effort to help improve your child's classroom performance, members of the multidisciplinary team (504 Team) will need to collect and review information on his/her learning behavior.

The teacher(s), guidance counselor, school psychologist, and other members may be involved in observations, interviews, the administration of behavior checklists, and other data collection activities.

Please sign below indicating your consent for this evaluation. Return the signed form to the Student Services Department. Once the information has been reviewed by the team we will notify you of an eligibility conference to gather additional information and discuss the results of any assessments and/or recommendations of the team.

A copy of your rights as a parent under Section 504 of the Rehabilitation Act is attached. You may contact the Student Services office at (908) 889-8288 ext 339 if you have any questions.

Parent/Guardian CONSENT for ADA/504 evaluation:

- ☐ I give my consent to proceed with the ADA/504 evaluation.
- ☐ I DO NOT give my consent to proceed with the ADA/504 evaluation.

Signature of Parent/Guardian: _____

Student Name: _____

Date: _____