**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

**Referral Information:**

[ ] Parent [ ] Student Assistance Team Date of SAT meeting: Click or tap here to enter text.

[ ] Other: Click or tap here to enter text.

**Suspected Disability Information:**

Suspected physical or mental impairment(s) - (Check all that apply):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Caring for self  | [ ]  Hearing | [ ]  Bending | [ ]  Digestive function | [ ]  Respiratory function |
| [ ]  Performing manual tasks | [ ]  Speaking | [ ]  Reading | [ ]  Normal cell growth |  [ ]  Circulatory function |
| [ ]  Walking | [ ]  Breathing | [ ]  Concentrating | [ ]  Bowel function |  [ ]  Endocrine function |
| [ ]  Seeing | [ ]  Learning | [ ]  Thinking | [ ]  Neurological function |  |
| [ ]  Communicating | [ ]  Eating | [ ]  Sleeping | [ ]  Brain function |  |
| [ ]  Standing | [ ]  Lifting | [ ]  Immune system | [ ]  Reproductive function |  |
| [ ]  Other – be specific: Click or tap here to enter text. |

Describe the suspected impact of the physical or mental impairment(s) checked above and note any observed difficulties resulting from the suspected physical or mental impairment(s):

Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click or tap here to enter text.

Signature of person making referral

Section 504 is designed to meet the individual educational needs of a student with a disability as adequately as the needs of students without disabilities.

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Dear Parent:

This letter is to inform you that the Section 504 Committee at your child’s school has concerns about your child’s academic and/or behavioral progress.

After reviewing your child’s current performance, we believe that additional information is necessary to fully determine your child’s educational needs and whether he/she might be eligible for accommodations in the general classroom under Section 504-a federal law that provides accommodations to identified students.

The District would like to conduct an evaluation of your child pursuant to Section 504 of the Rehabilitation Act of 1973. The first objective of an evaluation pursuant to Section 504 is to determine if your child has a physical or mental impairment that substantially limits your child in the performance of a major life activity. If your child does have such an impairment, then your child meets the definition of an “individual with a disability” under Section 504. If that is the case, the evaluation will also help us consider and develop, if necessary, an appropriate plan to serve and/or accommodate the needs of your child.

**We seek your consent for this evaluation**. The evaluation process may include such things as:

* interviews with teachers and other professionals knowledgeable about your child:
* observations of your child by teachers and other professionals; and
* the completion and gathering of checklists and/or recommendations from teachers and other professionals and other educational, behavioral and/or psychological evaluation measures including rating scales, depending on the nature of the suspected physical or mental impairment.

As part of the evaluation, we will also seek information directly from you through such activities as interviews, checklists, recommendations, and your observations. We welcome any other information you have that you are willing to share with us, such as diagnoses or reports from doctors, psychologists, counselors, tutors and others knowledgeable about your child. As part of the evaluation, we may seek your consent to release or exchange confidential information with your child’s physician or other service providers. All of these activities would be conducted at no expense to you.

Following the evaluation, we will hold a Section 504 Committee meeting at which we will consider all of this information along with the academic, health, and behavioral information we already have such as grades, test scores, attendance, health records, and disciplinary history. We will invite you to participate in this meeting.

Enclosed with this letter is a document entitled Notice of Rights and Procedural Protections Under Section 504 and the Americans with Disabilities Act. We ask you to read this document carefully and let us know if you have any questions.

If you would like us to conduct the evaluation of your child as we are proposing, please sign and return the enclosed Consent Form as well as the Parent Input form, both attached to this letter.

If you have any questions or concerns, please give me a call. You can reach me at: Click or tap here to enter text..

Sincerely,

Click or tap here to enter text.

Name and Title

Encl: Notice of Rights and Procedural Protections Under Section 504 and the Americans with Disabilities Act.

 Parent Informed Consent for Section 504 Evaluation

 Parent Input form

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text. [ ]  **Initial Evaluation** [ ]  **Reevaluation**

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Dear Parent/Guardian:

**A Section 504 Evaluation** typically consists of a review and interpretation of information from a variety of sources (i.e. existing educational records, staff reports/observations, grades, standardized test results, early intervening services, SAT interventions and progress monitoring, prior testing, and other data) in order to determine if your child qualifies as a student with a disability under Section 504.

If necessary, in addition to reviewing the data described above, as part of the Section 504 evaluation, the District requests to conduct the following assessments:

Click or tap here to enter text.

**Consent for Section 504 Evaluation:** We request your written informed consent for a Section 504 evaluation as described above.

If you **CONSENT** to the Section 504 evaluation, please mark the appropriate **CONSENT** box below, sign, date and return to the school Section 504 contact below.

If you **DO NOT CONSENT** to the Section 504 evaluation, please mark the appropriate **DO NOT CONSENT** box below, sign, date and return to the school Section 504 contact below.

Click or tap here to enter text.

Site Section 504 Contact- Printed Name

Click or tap here to enter text.

Phone/Extension

[ ]  I **CONSENT** to a Section 504 evaluation.

 [ ]  I **DO NOT CONSENT** to a Section 504 evaluation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­

Parent/Guardian Signature Parent/Guardian Printed Name Date

Enclosure: Notice of Rights and Procedural Protections Under Section 504 and the Americans with Disabilities Act

**DISTRICT/SCHOOL NAME**

This notice summarizes the procedural protections and rights of students who may have a disability under Section 504 of the Rehabilitation Act of 1973 ("Section 504") and their parents. Section 504 prohibits discrimination on the basis of disability including requiring that school districts implement procedures and take steps to ensure that a student with a disability under Section 504 receives an equal educational opportunity. Any person with concerns regarding compliance with the regulations implementing Section 504 with respect to students is directed to contact the district individual listed below.

**INTRODUCTION.** Section 504 of the Rehabilitation Act of 1973, along with the Americans with Disabilities Act, prohibit districts from discriminating against students with disabilities. Accordingly, Click or tap here to enter text. has adopted policies and procedures to ensure that discrimination does not take place. In the rest of this document, we will refer to these laws as “Section 504.”

**IDEA ELIGIBILITY.** Many students who meet the definition of an “individual with a disability” under Section 504 also qualify for services under the Individuals with Disabilities Education Act (IDEA). This document does not address these students or their parents. Such students are served pursuant to the requirements of the IDEA. The rights of parents of these students are spelled out in the Notice of Procedural Safeguards document promulgated by the State. The District complies with Section 504 by complying with the IDEA. The rest of this document addresses only the rights of parents of students who satisfy the definition of an individual with a disability under Section 504 but are not covered under the IDEA.

**AN APPROPRIATE EDUCATION.** If it is determined that your child meets the definition of an individual with a disability under Section 504, then your child will be entitled to a free and appropriate public education. This means that your child’s education will be designed to meet his/her individual educational needs as adequately as the needs of nondisabled students are met. A “free” public education means that no fees will be imposed on you except for the same fees that are imposed on parents of nondisabled students. However, insurance companies and other third parties that are obligated to provide or pay for services to your child are still obligated to do so.

**NOTICE.** You have the right to be notified the by District prior to any action that would identify your child as having a disability, evaluate your child under Section 504, or place your child in a program based on a disability.

**EVALUATION.** Prior to conducting an initial evaluation of your child under Section 504, the District will seek your informed written consent. An initial evaluation will not be conducted unless you give consent.

If formal tests are administered, the school will make sure that:

* all testing and other evaluation procedures are validated for the specific purpose for which they are used;
* they are administered by trained personnel in conformity with the instructions provided by the producer;
* they include tests and other evaluation materials designed to assess specific areas of educational need and not merely those designed to elicit a general IQ score; and
* tests are selected and administered to best ensure that they accurately measure what the test seeks to measure, rather than any sensory, speaking, or manual impairments the student may have (except when the test is designed to measure sensory, speaking, or manual skills).

An evaluation will be conducted prior to your child’s initial placement and will be conducted or reviewed prior to any subsequent significant change in placement.

If your child is identified as an individual with a disability under Section 504, the District will periodically reevaluate your child as appropriate.

**PLACEMENT.** If your child is identified as an individual with a disability under Section 504, placement decisions about your child will be made by the District’s Section 504 Committee, which will include persons knowledgeable about your child, the meaning of the evaluation data, and the placement options. You will be invited to participate in any meeting of the Section 504 Committee if your child’s Section 504 Plan, including services and/ or placement, is to be discussed. The Section 504 Committee will also ensure that your child is placed in the “least restrictive environment.”

**LEAST RESTRICTIVE ENVIRONMENT.** If your child is identified as an individual with a disability under Section 504, your child will be placed and served in the “least restrictive environment.” This means that your child will be served with students without disabilities in the regular education environment to the maximum extent appropriate. Prior to removing your child from the regular education environment due to his/her disability, the school will consider the use of supplementary aids and services (i.e., accommodations). Your child will be removed from the regular education environment only if he/she cannot be served satisfactorily in that environment even when supplementary aids and services are provided.

If it becomes necessary to serve your child in an alternate setting due to disability, the school will take into account the proximity of the alternate setting to your home.

**EXAMINATION OF RECORDS.** You have the right to see and examine any educational records that pertain to your child or are relevant in serving your child. This right is spelled out in School Board Policies.

**HEARINGS.** If you disagree with a decision of the Section 504 Committee regarding the identification, evaluation, or educational placement of your child, you have the right to an impartial hearing. You have the right to participate in such a hearing and to be represented by a person of your choice, including an attorney.

If you wish to request a hearing, you must make a written request for a hearing, unless you are not able to write. If you are not able to write, your request for a hearing may be made in your primary mode of communication. Your request for a hearing must be filed with the District’s Superintendent, or designee.

Upon receipt of a timely request for a hearing, the District will notify you of the date, time, and location of the hearing. If you disagree with the decision of the Hearing Officer, you have the right to a review procedure.

**OTHER COMPLAINTS.** You also have the right to file a complaint with the District’s Section 504 Coordinator pertaining to harassment, retaliation, or discrimination against your child in ways that do not involve your child’s identification, evaluation or educational placement. Any such complaint must be filed in accordance with the School Board Policy.

**OFFICE FOR CIVIL RIGHTS.** You also have the right to file a complaint with the United States Office for Civil Rights. The address of the Regional Office with jurisdiction in New Mexico is:

U.S. Department of Education

Office for Civil Rights, Region VIII

1244 Speer Boulevard, Suite 310

Denver, Colorado 80204-3582

303-844-5695 (telephone)

303-884-3417 (TTY)

303-844-4303 (facsimile)

<http://www.ed.gov/about/offices/list/ocr/index.html>

Procedural Safeguards provided by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Signature Date

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

What is the primary language spoken in the home? Click or tap here to enter text.

Has your child ever been retained/ repeated a grade? [ ]  No [ ]  Yes

If Yes, what grade? Click or tap here to enter text.

Has your child ever been referred to, or received accommodations or services, under any of the following programs?

[ ]  No [ ]  Yes\*

* Title One services
* Student Assistance Team
* English Language Learner (ELL)/ Limited English Proficiency
* Regular School Nursing Services
* School Health Services/ Health Plan
* Section 504
* Special Education

If Yes\*, complete the information below for **each** referral:

|  |  |  |
| --- | --- | --- |
| Name of State | Name of District | Name of Campus |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Do you have any concerns about your child in the following areas? [ ]  No [x]  Yes

If Yes, check **all areas of concern**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Caring for self  | [x]  Hearing | [ ]  Bending | [ ]  Digestive function | [ ]  Respiratory function |
| [ ]  Performing manual tasks | [ ]  Speaking | [ ]  Reading | [ ]  Normal cell growth |  [ ]  Circulatory function |
| [ ]  Walking | [ ]  Breathing | [ ]  Concentrating | [ ]  Bowel function |  [ ]  Endocrine function |
| [ ]  Seeing | [ ]  Learning | [ ]  Thinking | [ ]  Neurological function |  |
| [ ]  Communicating | [ ]  Eating | [ ]  Sleeping | [ ]  Brain function |  |
| [ ]  Standing | [ ]  Lifting | [ ]  Immune system | [ ]  Reproductive function |  |
| [ ]  Other – be specific: Click or tap here to enter text. |

Give a brief description of the concern(s): Click or tap here to enter text.

Has your child been diagnosed or identified with any physical or mental impairment related to the identified area(s) of concern or with any other physical or mental impairment?

[ ]  No [ ]  Yes

If Yes\*, provide the following information for each physician or other professional providing the diagnosis/ identification:

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis/Type of Impairment | Name of doctor or other professional  | Address of doctor or other professional | Is there an evaluation report? If so, provide the date of the report and attach a copy of the report, if available to you. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Date of last vision screening/ test: Click or tap here to enter text.

Does your child have any vision difficulties? [ ]  No [ ]  Yes

If Yes, please check all that apply:

[ ]  My child has prescription glasses or contact lenses

[ ]  My child has vision difficulties that are not correctable with prescription glasses or contact lenses

If your child has vision difficulties that are not correctable with prescription glasses or contact lenses, describe the difficulty and provide the name of the doctor that diagnosed the difficulty:

Click or tap here to enter text.

Diagnosed by: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Date of last hearing screening/ test: Click or tap here to enter text.

Does your child have any hearing difficulties? [ ]  No [ ]  Yes

If so, please check all that apply:

[ ]  My child has hearing aids

[ ]  My child has hearing difficulties that are not correctable with hearing aids

If your child has hearing difficulties, describe the difficulty and provide the name of the doctor that diagnosed the difficulty:

Click or tap here to enter text.

Diagnosed by: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Does your child take medication? [ ]  No [ ]  Yes \*

If yes, provide the following information for each medication taken by your child:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Frequency |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

\* If you checked “yes” to questions marked with a \*, you are requested to provide a Consent for Release of Confidential Information for each school, doctor, or other professional so that the District can obtain information that will help the 504 Committee determine your child’s needs.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Parent/Guardian Signature Date

Click or tap here to enter text.

Parent/Guardian Printed Name

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name:Click or tap here to enter text. Teacher Name: Click or tap here to enter text.

Subject(s): Click or tap here to enter text. Class Period: Click or tap here to enter text.

Student’s Current Grade Average: Click or tap here to enter text.

How long have you known the student? Click or tap here to enter text. years Click or tap here to enter text. months

Have you taught this student previously? [ ] Yes [ ]  No; If yes, when and what subject or grade? Click or tap here to enter text.

Do you have any concerns about the student in the following areas? [ ] No [ ] Yes

If yes, check all areas of concern:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Caring for self  | [ ] Hearing | [ ]  Bending | [ ]  Digestive function | [ ]  Respiratory function |
| [ ]  Performing manual tasks | [ ]  Speaking | [ ]  Reading | [ ]  Normal cell growth | [ ]  Circulatory function |
| [ ]  Walking | [ ]  Breathing | [ ]  Concentrating | [ ]  Bowel function | [ ]  Endocrine function |
| [ ]  Seeing | [ ]  Learning | [ ]  Thinking | [ ]  Neurological function |  |
| [ ]  Communicating | [ ]  Eating | [ ]  Sleeping | [ ]  Brain function |  |
| [ ]  Standing | [ ]  Lifting | [ ]  Immune system | [ ]  Reproductive function |  |
| [ ]  Other – be specific: Click or tap here to enter text. |

Give a brief description of the concern(s): Click or tap here to enter text.

Do you have any academic or behavioral concerns about this student? [ ]  No [ ]  Yes

If so, describe your concerns: Click or tap here to enter text.

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

Describe any MLSS layered interventions you have provided and rate the effectiveness of the assistance on a scale of 1 to 5 with 1 being “not at all effective” and 5 being “very effective.”

|  |  |  |
| --- | --- | --- |
| Dates | Intervention Service | Effectiveness |
| Click or tap here to enter text. | Click or tap here to enter text. | [ ] 1 [ ] 2 [ ]  3 [ ]  4 [ ] 5 |
| Click or tap here to enter text. | Click or tap here to enter text. | [ ] 1 [ ] 2 [ ]  3 [ ]  4 [ ] 5 |
| Click or tap here to enter text. | Click or tap here to enter text. | [ ] 1 [ ] 2 [ ]  3 [ ]  4 [ ] 5 |

Attach MLSS layered intervention data, including short-cycle assessments and samples of student work.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Signature of person completing form Printed name of person completing form

Name, Title

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Teacher Name: Click or tap here to enter text.

**Vision**

Date of most recent screening: Click or tap here to enter text. Referral Date (if necessary) Click or tap here to enter text.

Right: Click or tap here to enter text. Left: Click or tap here to enter text.

**Hearing**

Date of most recent screening: Click or tap here to enter text. Referral Date (If necessary) Click or tap here to enter text.

Right: [ ]  passed [ ]  failed

Left: [ ]  passed [ ]  failed

**Current medications administered at school:**

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Frequency |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Excluding routine medication visits, how many times has the student been to the nurse's office:

 This school year: Click or tap here to enter text.

 Last school year: Click or tap here to enter text.

Does the student have or has the student had an Individual Healthcare Plan or has the student received regular health services?

 [ ]  No [ ]  Yes If yes, attach a copy of the plan. If you do not have a copy of the plan, explain. Click or tap here to enter text.

Do you have any health concerns about this student? [ ]  No [ ]  Yes

If so, describe your concerns. Click or tap here to enter text.

Has the parent provided you with any information regarding a physical or mental impairment of the student? [ ]  No [ ]  Yes

If so, what condition was identified or diagnosed? Click or tap here to enter text.

Attach any written documentation regarding a physical or mental impairment.

Click or tap here to enter text. Date: Click or tap here to enter text.

Name and title of person completing form

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

**DISTRICT/SCHOOL NAME**

Date

Addressee

Dear Click or tap here to enter text.:

The school has gathered the evaluation information and completed any assessments of your child pursuant to Section 504 of the Rehabilitation Act of 1973 that are necessary to determine 1) whether your child meets the definition of an “individual with a disability” under Section 504; and 2) the needs of your child. A Section 504 Committee meeting to review the evaluation results and determine whether your child meets the definition of an “individual with a disability” under Section 504 will be held at the following time and location:

**Location:** Click or tap here to enter text. **Date:** Click or tap here to enter text. **Time:** Click or tap here to enter text.

If the Section 504 Committee identifies your child as a child with a disability under Section 504, the Committee will develop an individualized Section 504 Plan to ensure that your child receives an equal educational opportunity.

As a parent, you are a partner in your child's education, and your input into the decisions of the Section 504 Committee is important. We would like you to attend the Section 504 Committee meeting.

If you have any questions, cannot attend, or if this meeting time is not convenient for you, please call me at Click or tap here to enter text.. We will discuss your questions or arrange a mutually convenient meeting time. A description of your rights under Section 504 is attached.

Sincerely,

Click or tap here to enter text.

Section 504 Representative

Section 504 is designed to meet the individual educational needs of a child with a disability as adequately as the needs of nondisabled peers.

Encl: Section 504 Procedural Safeguards

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Dear Parent or Guardian:

This letter is to invite you to a Section 504 meeting to review your child’s Section 504 plan and continued eligibility.

We have scheduled a meeting on (date) Click or tap here to enter text. at (time) Click or tap here to enter text..

This meeting will be held at (location) Click or tap here to enter text..

The meeting is scheduled for the following reason(s)

[ ]  Annual review

[ ]  Intermittent review

[ ]  Re-evaluation

[ ]  Manifestation Determination (prior to disciplinary removal constituting a change in placement)

[ ]  Other: Click or tap here to enter text.

As a parent, you are a partner in your child's education, and your input into the decisions of the Section 504 Committee is important. We would like you to attend the Section 504 Committee meeting.

If you have any questions, cannot attend, or if this meeting time is not convenient for you, please call me at Click or tap here to enter text.. We will discuss your questions or arrange a mutually convenient meeting time. A description of your rights under Section 504 is attached.

Sincerely,

Click or tap here to enter text.

Section 504 Representative

Encl: Section 504 Procedural Safeguards

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text. [ ]  **Initial Evaluation** [ ]  **Reevaluation**

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

The Section 504 Committee must include persons with knowledge of the student, the meaning of the evaluation data and the placement options.

|  |  |  |
| --- | --- | --- |
| Name/Signature | Position/Title | Date |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Evaluation Data Considered from a Variety of Sources:

The Section 504 Committee reviewed and carefully considered the following data gathered from a variety of sources.

(Please check each that applies, attach copies of the data and document discussions on Notes page.)

|  |  |  |
| --- | --- | --- |
| [ ]  Grade Reports | [ ]  Parent Input | [ ]  Standardized Tests  |
| [ ]  Student Input | [ ]  Student Work Samples | [ ]  Language Dominance |
| [ ]  MLSS Intervention Data | [ ]  Disciplinary Records/Referrals | [ ]  Mitigating Measures |
| [ ]  School Health Information | [ ]  Medical Evaluations/Diagnoses | [ ]  Previous Special Education Records |
| [ ]  Other: Click or tap here to enter text. |

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

The following information provided by the parents (Note: attach copies of any report, recommendation or evaluation provided by the parents, and summarize any verbal input): Click or tap here to enter text.

Medical reports/ records (include Physician’s Statement) if applicable: Be specific: Click or tap here to enter text.

Other input - Be specific: Click or tap here to enter text.

**CONSIDERATION OF MAJOR LIFE ACTIVITIES**

What is the major life activity that may be impacted? For impairments in remission or episodic, identify activity or

function affected when the disability is present.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Caring for self  | [ ]  Hearing | [ ]  Bending | [ ]  Digestive function | [ ]  Respiratory function |
| [ ]  Performing manual tasks | [ ]  Speaking | [ ]  Reading | [ ]  Normal cell growth | [ ]  Circulatory function |
| [ ]  Walking | [ ]  Breathing | [ ]  Concentrating | [ ]  Bowel function | [ ]  Endocrine function |
| [ ]  Seeing | [ ]  Learning | [ ]  Thinking | [ ]  Neurological function |  |
| [ ]  Communicating | [ ]  Eating | [ ]  Sleeping | [ ]  Brain function |  |
| [ ]  Standing | [ ]  Lifting | [ ]  Immune system | [ ]  Reproductive function |  |
| [ ]  Other – be specific: Click or tap here to enter text. |

**CONSIDERATION OF PHYSICAL OR MENTAL IMPAIRMENT**

What data has the Committee considered to establish that the student has/continues to have a physical or mental impairment? Be specific, and list all sources of data: Click or tap here to enter text.

* NOTE: if the data does not support the existence of a physical or mental impairment, the school cannot identify the student as an individual with a disability under Section 504.

Based upon a review of the data cited above, does the student have a physical or mental impairment affecting one or more major life activities to some degree when disregarding mitigating measures? [ ]  Yes [ ]  No

If “YES” what is the nature of the physical or mental impairment affecting the major life activity? Click or tap here to enter text.

If “NO” the student cannot be identified as an individual with a disability under Section 504.

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

**CONSIDERATION OF DISABILITY**

When **disregarding mitigating measures**, does the student’s physical or mental impairment “substantially limit” the student’s performance of one or more major life activity in comparison with how most students in the general population and of the same chronological age perform the major life activity?

[ ]  Yes, Substantial [ ]  No, Moderate [ ]  No, Mild

If the student’s impairment is **episodic or in remission**, does the student’s physical or mental impairment substantially limit the student’s performance of one or more major life activity when **active**?

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **Based on the evaluation data gathered from a variety of sources, the Section 504 Committee answered the following questions to determine Section 504 identification** |
|[ ] [ ]  1. Does the student have a physical or mental impairment? If so, describe the impairment. Click or tap here to enter text. |
|[ ] [ ]  2. Does the physical or mental impairment affect one or more major life activities? If so which major life activity or activities is/are affected?Click or tap here to enter text. |
|[ ] [ ]  3. When **disregarding the mitigating measures**, does he physical or mental impairment **substantially limit** the major life activity? Click or tap here to enter text. |

[ ]  Yes, Substantial [ ]  No, Moderate [ ]  No, Mild

**IDENTIFICATION**

* If ***all three*** questions were answered “Yes”, the student is a student with a disability under Section 504.

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

**DETERMINATION**

|  |
| --- |
| **The Section 504 Committee’s analysis of the identification criteria as applied to the evaluation data indicates the following:** |
|[ ]  The student **cannot** be identified as an individual with a disability under Section 504 because the data does not establish the existence of a physical or mental impairment. |
|[ ]  The student **cannot** be identified as an individual with a disability under Section 504 because the student’s physical or mental impairment **does not substantially limit** the student in a major life activity even when **disregarding the positive effects of mitigating measures** that lessen the impact of the impairment.  |
|[ ]  The student has or continues to have, a physical or mental impairment that substantially limits the student’s performance of a major life activity; and therefore is an identified individual with a disability. The impairment is:[ ]  Active [ ]  Episodic [ ]  In remissionThe Section 504 Committee will determine the type of accommodation plan necessary to meet his/her individual educational needs as adequately as the needs of nondisabled students are met.  |
|[ ]  The student may have a physical or mental impairment that substantially limits learning, or another major life activity in such a way that the student **may require** the provision of special education (i.e., specially designed instruction). Therefore, the student will be referred for a full individual evaluation to determine eligibility for special education services under the Individuals with Disabilities Education Act (IDEA).[ ]  For an Initial Section 504 meeting, pending the determination of the student’s eligibility for special education services, the student will continue to receive MLSS interventions in general education. [ ]  For a review Section 504 meeting, the Section 504 Plan previously in place will remain in effect pending the determination of the student’s eligibility for special education services. |
|[ ]  The student is no longer eligible as a student with a disability under Section 504. The student will receive general education services without the support of Section 504.  |

**NEED FOR ACCOMMODATIONS:**

|  |
| --- |
| **Based on the evaluation data and the determination of Section 504 eligibility, the Section 504 committee has determined the student does have a physical or mental impairment that substantially limits a major life activity and** |
|[ ]  **requires** accommodations and /or services through a Section 504 plan |
|[ ]  at this time, **does not require** accommodations and/or services through a Section 504 Plan due to [ ]  Physical /mental impairment being in remission.[ ]  Positive effects of mitigating measures currently in use.  |

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

ADDITIONAL INFORMATION AND NOTES:

Click or tap here to enter text.

Click or tap here to enter text.

Name and title of person recording notes

Date: Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

The Section 504 Committee met on Click or tap here to enter text. (date) to review evaluation data and to determine whether your child is a child with a disability under Section 504 due to a physical or mental impairment that substantially limits a major life activity. The Section 504 Committee determined that your child:

|  |
| --- |
|[ ]  The student **DOES** have a physical or mental impairment that substantially limits a major life activity and **requires** accommodations and/or services through a Section 504 plan. Your child has been identified as a student with a disability under Section 504 due to the following physical or mental impairment: Click or tap here to enter text.  |
|[ ]  The student **DOES** have a physical or mental impairment that substantially limits a major life activity, and **DOES NOT** **require** accommodations and/or services through a Section 504 plan, due to [ ]  the physical or mental impairment is in remission[ ]  the positive effects of mitigating measures currently in use. |
|[ ]  The student **DOES NOT** have a physical or mental impairment or any identified impairment that substantially limits a major life activity. The student is **NOT** eligible as a student with a disability under Section 504.  |
|[ ]  The student **NO LONGER** has a physical or mental impairment that substantially limits a major life activity. The student is no longer Section 504 eligible. |
|[ ]  The school has policies and procedures in effect prohibiting discrimination based on disability due to a record of having a disability or based on the false perceptions of others that the student has a disability.  |
|[ ]  The student **DOES NOT** currently have a physical or mental impairment that substantially limits a major life activity but **has a record** of such an impairment. As a result, your child is **not entitled** to an affirmative Section 504 process including a Section 504 Plan.  |
|[ ]  The student **DOES NOT** currently have a physical or mental impairment that substantially limits a major life activity **or a record** of such an impairment. As a result, your child is not entitled to an affirmative Section 504 process including a Section 504 Plan.  |

A copy of the Section 504 evaluation and eligibility determination is attached. If you have any questions concerning this decision, please call: Click or tap here to enter text. at: Click or tap here to enter text..

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text. [ ]  **Initial** [ ]  **Annual Review** [ ]  **Intermittent Review**

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Date of Evaluation: Click or tap here to enter text. Date of Eligibility Determination: Click or tap here to enter text.

The Section 504 Committee must include persons with knowledge of the student, the meaning of the evaluation data and the placement options.

|  |  |  |
| --- | --- | --- |
| Name/Signature | Position/Title | Date |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

The school’s Section 504 Committee has identified the student as an individual with a disability under Section 504 and the Americans with Disabilities Act due to a physical or mental impairment that substantially limits a major life activity.

**MITIGATING MEASURES CURRENTLY IN EFFECT**

|  |  |
| --- | --- |
| The student is currently utilizing the following mitigating measures that lessen the effects of the impairment and do not require monitoring or any involvement by the school.The Committee will reconsider the need for services 1) at an annual meeting of the Section 504 Committee, and 2) at any other time at school or parent request. | Click or tap here to enter text. |
| The student is currently utilizing the following mitigating measures either in-school or out of school that require some type of monitoring and communication, contingency or emergency measures, or services by the school: | Click or tap here to enter text. |
| The school will provide the following monitoring of or assistance with the mitigating measures while the student is in school (e.g., battery check, device check, periodic checks for skin rash or allergic reaction, medication administration at school): | Click or tap here to enter text. |
| The school will provide the following mitigating measures (e.g., assistive technology, reasonable accommodations, MLSS, auxiliary aids or services): | Click or tap here to enter text. |
| The parents should be contacted if the following occurs: | Click or tap here to enter text. |

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

**NEEDED ACCOMMODATIONS**

| Student need Identified by Evaluation  | Accommodation to Address Need | Special Materials/Training Needed | Criteria for Evaluating Success |
| --- | --- | --- | --- |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**NEEDED RELATED SERVICES:**

|  |  |  |  |
| --- | --- | --- | --- |
| Related Service | Frequency | Location | Duration  |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**DISCIPLINE:**

[ ]  The student will follow the school-wide discipline plan subject to Section 504 discipline procedures, i.e., Manifestation Determination review requirements.

[ ]  The student requires a Functional Behavior Assessment (FBA) and Behavioral Intervention Plan (BIP) as a supplement to the school-wide discipline plan.

|  |  |
| --- | --- |
| Functional Behavior Assessment | Behavior Intervention Plan  |
|[ ]  In Progress |[ ]  In Progress |
|[ ]  Date FBA completed: Click or tap here to enter text. |[ ]  Date BIP Completed: Click or tap here to enter text. |
|[ ]  Date FBA Reviewed by Section 504 Committee: Click or tap here to enter text. |[ ]  Date BIP Reviewed by Section 504 Committee:Click or tap here to enter text. |

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

**HEALTH CARE PLAN**

[ ]  A Health Care Plan is needed and attached as part of the student’s Section 504 Plan.

The Committee determined that the nurse, in consultation with the Parent, can revise the Health Care Plan of the

student based on new physician’s orders.

[ ]  Yes [ ]  No (If no, the Committee will need to re-convene if new physician’s orders are issued.)

**EMERGENCY/CONTINGENCY PLANS**

[ ] Check if this plan is for a student whose impairment is episodic, in remission, or otherwise not active at present.

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text. [ ]  **Annual** [ ]  **Intermittent**

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Date of current Section 504 plan: Click or tap here to enter text. Date of current evaluation: Click or tap here to enter text.

The Section 504 Committee must include persons with knowledge of the student, the meaning of the evaluation data and the placement options.

|  |  |  |
| --- | --- | --- |
| Name/Signature | Position/Title | Date |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**INFORMATION THAT WAS REVIEWED AND CONSIDERED:**

Parent Information:

Click or tap here to enter text.

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

Medical reports/ records (be specific):

 Click or tap here to enter text.

Other input (be specific):

Click or tap here to enter text.

**REVIEW OF MONITORING AND COMMUNICATION PLAN**

The Section 504 Committee reviewed the mitigating measures currently being used by the student and determined:

|  |
| --- |
|[ ]  The mitigating measures effectively address the student’s impairment and **no supports** are needed within the school. |
|[ ]  The mitigating measures effectively address the student’s impairment, but a **plan to monitor** the measures, communicate with the parent, and/or contingency or emergency plan is needed, and a Section 504 plan was developed. |
|[ ]  The mitigating measures do not effectively address the student’s impairment, and **additional supports** are needed, and a Section 504 plan was developed.  |

**REVIEW OF EXISTING SECTION 504 PLAN**

The Section 504 Committee reviewed the current Section 504 plan and determined:

|  |
| --- |
|[ ]  The mitigating measures effectively address the student’s impairment and **no supports** are needed within the school. |
|[ ]  The mitigating measures effectively address the student’s impairment, but a **plan to monitor** the measures, communicate with the parent, and/or contingency or emergency plan is needed, and a Section 504 plan was developed. |
|[ ]  The mitigating measures do not effectively address the student’s impairment, and **additional supports** are needed, and a Section 504 plan was developed.  |
|[ ]  The current Section 504 plan continues to meet the individual educational needs of the student asadequately as the needs of his/ her nondisabled peers and no revisions are needed. The Section 504 Planwill remain in effect. **No revisions needed**. |
|[ ]  The current Section 504 plan **requires revisions** to continue to meet the individual educational needs ofthe student as adequately as the needs of his/ her nondisabled peers. A revised Section 504 Plan wasdeveloped. |
|[ ]  The Committee believes that the student may have a physical or mental impairment that substantiallylimits learning, or another major life activity in such a way that the student may require the provision ofspecial education (i.e., specially designed instruction). Therefore, the student has been referred for a fullindividual evaluation to determine eligibility for special education services under the Individuals withDisabilities Education Act (IDEA). |

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

ADDITIONAL INFORMATION AND NOTES: Click or tap here to enter text.

Click or tap here to enter text.

Name and title of person recording notes

Date: Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text. [ ]  **Initial Review** [ ]  **Annual Review** [ ]  **Intermittent Review**

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

**PARENT CONSENT FOR INITIAL SECTION 504 PLACEMENT**

I have received a copy of the Initial Section 504 plan for my student along with a copy of the Notice of Rights and Procedural Protections under Section 504. I understand my rights and the offer of accommodations/services in the Section 504 Plan.

|  |
| --- |
| INITIAL SECTION 504 PLACEMENT |
|[ ]  I **DO CONSENT** to the initial placement of my student under Section 504. My student will receive the accommodations/services outlined in the Section 504 plan.  |
|[ ]  I **DO NOT CONSENT** to the initial placement of my student under Section 504. The Section 504 plan will not be implemented. I understand I can request a Section 504 Committee meeting any time to revisit Section 504 eligibility and the need for accommodations and/or services. |
| Parent Printed Name: Click or tap here to enter text. Date: Click or tap here to enter text.Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parent Printed Name: Click or tap here to enter text. Date: Click or tap here to enter text.Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| CONTINUATION OF SECTION 504 PLACEMENT |
|[ ]  I have received a copy of the Section 504 plan for my student along with a copy of the Notice of Rights and Procedural Protections under Section 504. I understand my rights and the offer of accommodations/services in the Section 504 Plan. |
|[ ]  I **REVOKE CONSENT** for my student to continue to receive accommodations and/or services offered through the Section 504 plan. The Section 504 plan will not be implemented. I understand I can request a Section 504 Committee meeting any time to revisit Section 504 eligibility and the need for accommodations and/or services. |
| Parent Printed Name: Click or tap here to enter text. Date: Click or tap here to enter text.Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parent Printed Name: Click or tap here to enter text. Date: Click or tap here to enter text.Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Date of exam: Click or tap here to enter text. Recommended follow-up exam date? Click or tap here to enter text.

Referral to another physician? [ ]  Yes [ ]  No

If yes, please provide the name and address of the physician: Click or tap here to enter text.

Please list the student’s diagnosis (i.e., physical or mental impairment)? Click or tap here to enter text.

Current medications:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Frequency |
| Click or tap here to enter text.  | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

What effects, if any, will the medications have on the student’s learning (e.g., concentration, attention span, emotional side effects)? Click or tap here to enter text.

Please describe how the student’s medical diagnosis may interfere with the student’s ability to function at school:

Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Licensed Physician’s Signature Telephone Number

Click or tap here to enter text. Click or tap here to enter text.

Physician’s Printed/Typed Name Date

Click or tap here to enter text.

Address

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Parent(s) Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

At this time, we are requesting your consent for a Functional Behavior Assessment (FBA) to collect new information in order to better understand your child's behavior at school. Behavior is broadly defined and includes any behavior that is frequent, persistent or severe and may include but is not limited to inattention, impulsivity, study skills, aggression, poor work completion, poor attendance, social interactions with peers, etc.

Please be aware that an FBA is a problem-solving process that looks beyond the behavior itself to identify the student specific factors associated with the occurrence (and non-occurrence) of specific behaviors. Conducting an FBA lays the foundation for developing a Behavior Intervention Plan (BIP), if indicated, that is intended to teach the student replacement behaviors. An FBA may include collecting information in the following ways:

* Parent/Student interview
* Teacher interview
* Classroom observation
* Data collection including, but not limited to Scatterplot, ABC (Antecedent-Behavior-Consequence) Chart, work samples, etc.

This process is intended to help us understand your child's educational needs. We believe that with your help, we can

positively affect your child's scholastic progress. Thank you for joining us in support of your child.

**Consent for Functional Behavior Assessment (FBA):**

[ ]  I **DO** give permission to collect new information to conduct a Functional Behavior Assessment.

[ ]  I **DO NOT** give permission to collect new information to conduct a Functional Behavior Assessment, however, I understand that existing information can be used to conduct a Functional Behavior Assessment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Parent/Guardian Signature Date

Click or tap here to enter text.

Parent/Guardian Printed Name

**DISTRICT/SCHOOL NAME**

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

School: Click or tap here to enter text. Grade: Click or tap here to enter text. DOB: Click or tap here to enter text.

Date of current Section 504 Plan: Click or tap here to enter text. Date current evaluation: Click or tap here to enter text.

The Section 504 Committee must include persons with knowledge of the student, the meaning of the evaluation data and the placement options.

|  |  |  |
| --- | --- | --- |
| Name/Signature | Position/Title | Date |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

**Evaluation Data Considered from a Variety of Sources:**

The Section 504 Committee reviewed and carefully considered the following data gathered from a variety of sources.

Please check each that applies and attach copies of the data.

|  |  |
| --- | --- |
|[ ]  Grade Reports |[ ]  Student Work Samples |
|[ ]  Parent Input |[ ]  Student Input |
|[ ]  Standardized Tests and Other tests |[ ]  Teacher Input |
|[ ]  Language Dominance |[ ]  School History/Attendance |
|[ ]  MLSS Intervention Data |[ ]  Discipline Records/Referrals |
|[ ]  Administrator Input |[ ]  Mitigating Measures |
|[ ]  School Health Information |[ ]  Medical Evaluations/Diagnoses |
|[ ]  Previous Special Education Records |  |  |
|[ ]  Other (Specify): Click or tap here to enter text. |

**Section 504 Manifestation Determination:**

Description of Misconduct (Note: *The Section 504 Committee does not address whether or not the alleged behavior occurred.)*:

Click or tap here to enter text.

Description of proposed disciplinary action:

Click or tap here to enter text.

Does the proposed disciplinary action constitute a change of placement?

[ ]  No (If NO, proceed with disciplinary action.)

[ ]  Yes (If YES, continue with manifestation determination review.)

Is the proposed disciplinary action based on the student’s illegal use of drugs, or for the use or possession of alcohol?

[ ]  Yes (If YES, the student is subject to the same disciplinary penalty imposed on nondisabled students who engage in the same behavior. The Committee will not conduct a manifestation determination.)

[ ]  No (If NO, continue with the manifestation determination review.)

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

**Section 504 Review**

|  |
| --- |
| List the student’s qualifying physical or mental impairment(s):Click or tap here to enter text. |
| Description of current 504 Plan accommodations and/or services, including FBA and BIP:Click or tap here to enter text. |
| List prior discipline referrals and any Out of School Suspension (OSS) days:Click or tap here to enter text. |
| Teacher /Staff observations including attendance, grades, behavioral concerns, if any:Click or tap here to enter text. |
| Parent input:Click or tap here to enter text. |

**Determination:**

Following the review of all relevant information, including but not limited to, information contained in the student’s file, the student’s accommodation plan and/or BIP, teacher observations and any information provided by the parents, the Section 504 Committee has made the following determinations:

**Question 1**

Was the conduct in question caused by, or directly and substantially related to the student's disability?

[ ]  Yes [ ]  No

**Question 2**

Was the conduct in question the direct result of the school's failure to implement the student's Section 504 plan? [ ]  Yes [ ]  No

Date: Click or tap here to enter text.

Student Name: Click or tap here to enter text. Student ID#: Click or tap here to enter text.

**Results**:

If either question is answered YES, the Committee will conduct a Functional Behavioral Assessment (FBA), unless this had been done prior to the behavior in question. The Committee will also implement a behavioral intervention plan (BIP) for the student. If the student already has a BIP, the Committee will review and modify the BIP as necessary to address the behavior. The Committee will also return the student to the placement from which the student was removed unless:

 1) the parent and school agree otherwise as part of the modification of the student’s Section 504 Plan, including BIP; or

2) the student’s misconduct involved weapons or the infliction of a serious bodily injury to another person.

If the second question is answered YES, the Committee will take immediate steps to remedy the deficiencies in the implementation of the Section 504 Plan.

If both questions are answered NO, the student is subject to the same discipline procedures applicable to students without disabilities.

**Notes**:

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