REQUEST FOR SECTION 504 ACCOMMODATIONS 2020-2021

Name of Student _____ DOB ___/___/___ Student ID# _____

School Name _____ School ATS/DBN: _____ Grade/Class _____

Name of Requesting Parent/Guardian _____ Relationship to Student _____

Date Submitted to the 504 Coordinator ___/___/___ Name of 504 Coordinator _____

Does the student have a current IEP? ☐ Yes ☐ No 504 Coordinator Tel. # _____

Part 1: Parent/Guardian must complete and submit to the school's 504 Coordinator

Describe the concern below and how it affects the student's performance at school:

Request accommodations based on the concerns listed above. Please contact your school's 504 Coordinator with any questions.

Request for Accommodation(s) *Check all requested:*		***For school use only*** **New**	***For school use only*** **Renewal**
Testing Accommodations	☐ Test schedule/administration time (e.g. extended time, etc.)	☐	☐
	☐ Test setting/location	☐	☐
	☐ Method of presentation/Directions/Assistive Technology	☐	☐
	☐ Method of test response/content support	☐	☐
	☐ Other (please specify)	☐	☐
Classroom / Curriculum Accommodations	☐ Class schedule/use of time	☐	☐
	☐ Class activities setting	☐	☐
	☐ Method of presentation/Directions/Assistive Technology	☐	☐
	☐ Method of class activities response/Content Support	☐	☐
	☐ Other (please specify)	☐	☐
Academic Supports and Other Services	☐ Paraprofessional	☐	☐
	☐ Nursing Services	☐	☐
	☐ Transportation *(complete OPT Medical Exception Request Form)*	☐	☐
	☐ Safety Net *(high school only)*	☐	☐
	☐ Other (please specify) _____	☐	☐

When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse. Requests for 1:1 nursing, paraprofessional support, and transportation will be reviewed on a case-by-case basis. Requests must be reviewed by an Office of School Health Practitioner in order to confirm that services are medically needed. Additional forms must be completed; please check with your 504 Coordinator.

Part 2: PARENT CONSENT – Parent/Guardian must complete before submitting to your school's 504 Coordinator

Your child may qualify for accommodations under Section 504 of The Rehabilitation Act of 1973. Your school's 504 team will meet to review your child's records, classwork, classroom observations, testing, and health care practitioner's statement. If your child qualifies for services based on that review, the team will create a 504 plan with your help and consent. The 504 plan may be reviewed at any time of the year, **but 504 plans must be reapproved each school year.**

By signing this form: 1) You are giving consent to the 504 team to review your child's records and decide if your child qualifies for accommodation services. 2) You confirm that you have provided full and complete information to the best of your ability. 3) You understand that the Office of School Health (OSH), and the Department of Education (DOE) are relying on the accuracy of the information on the form for their review and decisions. 4) You understand that OSH and DOE may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

☐ **Completed HIPAA form attached (REQUIRED FOR REVIEW. PARENTS MUST COMPLETE THE BACK OF THIS FORM**).

Name of Parent/Guardian _____ Daytime Phone Number _____

Signature of Parent/Guardian _____ Date _____