

PARENT REFERRAL FORM

Referral for Section 504 Eligibility

Student _____ Student ID# _____

Parent's Name _____ Phone # _____ Date _____

The following attempts were initiated prior to this referral:

1) A professional has formally diagnosed the student with a mental or behavioral disorder. Yes No

If yes, please list diagnosis _____

2) Student is (or has in the past) receiving counseling. Yes No

If yes, please list dates _____

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

4) Student has received special education services in the past. Yes No

If yes, please list grade(s) and school(s) _____

5) Please comment on the student's physical health _____

Home/academic behaviors (please check if applicable)

_____ (1) Good study habits.

_____ (2) Completes homework regularly.

_____ (3) Follows parent's directions.

_____ (4) Completes tasks and chores.

_____ (1) Refuses to complete homework.

_____ (2) Neglects household responsibilities.

_____ (3) Defiant.

_____ (4) Other: _____

6) Please list discipline/consequences that have been implemented. _____

7) 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.) _____

Parent Signature _____

Additional information for the referring parent

A group consisting of the parent(s), the student, the 504 Coordinator, all of the student's teachers and any other appropriate staff members determine eligibility. It is very important that the student attend the meeting, as his/her input is helpful in determining reasonable accommodations.

Please return this form to: **504 Coordinator**

Date Received: _____

INFORMATION AND PROCEDURES
For Disability and Accommodation Determination
SECTION 504 OF THE REHABILITATION ACT OF 1973

Dear Diagnosing Professional:

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, completed, and submitted to the school's 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 an 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 function, 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.

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 supports might be required for this student's achievement in high school.

1. The purpose of certification of a diagnosed disability 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 Diagnosing 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 supports.
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 an "incomplete" at the end of a grading period. The student must successfully complete coursework and assessments in order to receive course credit.

Parent/Guardian Signature

Date

Diagnosing Professional Signature

Date

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's Fax Number _____

Diagnosing Professional's Address _____

(Street)

(City, State, Zip)

Parent/Guardian Name (Type or Print)

Parent/Guardian Phone

Parent/Guardian Signature

Date