

REFERRAL FOR SUSPECTED SECTION 504 DISABILITY

Student Name _____ DOB _____

School _____ Grade _____

Parent Name(s) _____

Address _____ Phone _____

A. Statement of Suspected Section 504 Disability (Please check the statement(s) which apply).

I suspect that this student:

_____ may have a physical or mental impairment that substantially limits one (1) or more major life activities (e.g., walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and/or performing manual tasks);

_____ may have a record of such an impairment; or

_____ may be regarded as having such an impairment.

B. Nature of the Concern (attach additional sheets if necessary).

1. State the suspected physical or mental impairment and any evaluative/data source supporting the diagnosis.

2. Indicate which major life activity(ies) is(are) limited.

3. Indicate how the major life activity is substantially limited.

C. Reason(s) for Referral (list specific concerns/behavior).

D. **To date, what accommodations or special provisions have been made to assist the student?**

Signature of Person Making Referral

Relationship to Student

Date

The signature of the principal receiving this referral documents that a copy of this form and the Notice of Parent/Student Rights have been given or sent to the parent or guardian.

Principal's Signature

Date Received

Copies to: Parent/Guardian

Cumulative Folder