

SECTION 504 STUDENT ACCOMMODATION PLAN

Student _____
School _____
Review Date _____

Date _____
DOB _____
Case Manager _____

Part 1: Justification for services

1. The student has a physical or mental impairment that substantially limits one or more of his/her major life activities.

YES NO

- | | |
|--|---|
| <input type="checkbox"/> walking | <input type="checkbox"/> working |
| <input type="checkbox"/> breathing | <input type="checkbox"/> helping |
| <input type="checkbox"/> learning | <input type="checkbox"/> eating |
| <input type="checkbox"/> reading | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> concentrating | <input type="checkbox"/> standing |
| <input type="checkbox"/> thinking | <input type="checkbox"/> lifting |
| <input type="checkbox"/> communicating | <input type="checkbox"/> bending |
| <input type="checkbox"/> seeing | <input type="checkbox"/> operation of a bodily function |
| <input type="checkbox"/> speaking | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> caring for one's self | |

2. Is the student identified for Section 504 accommodations?

YES NO

3. Briefly document the basis for determining the disability.

4. _____

6. Describe areas of need and action to be taken. _____

Part I – Required Accommodations

Area _____

Accommodations _____

Evaluation _____

Area _____

Accommodations _____

Evaluation _____

Area _____

Accommodations _____

Evaluation _____

Area _____

Accommodations _____

Evaluation _____

I give permission for my student to receive the above mentioned services.

Parent

Date