REQUEST FOR SECTION 504 ACCOMMODATIONS –OFFICE OF SCHOOL HEALTH- SCHOOL YEAR 2014-2015

PART 1: REQUEST FOR SECTION 504 EDUCATION ACCOMMODATIONS- To be completed by individual requesting accommodations. Submit to school 504 Coordinator

Date submitted to 504 Coordinator:		DBN:		School Name:	
Name of person submitting request:		Student Name:		Student DOB:	
Relationship to student:		Student ID #:		Grade/Class:	

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

Indicate accommodations requested based on the concern above. Please consult the school-based 504 Coordinator with any questions.

Request for Educational Accommodation(s) *Check all requested:*		***For school use only***	
		Approve	**Deny**
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 Services	□ Paraprofessional services*	□	□
	□ Safety Net *(high school only)*	□	□
	□ Other (please specify)	□	□
Scheduling / Other (?)	□ Barrier-free site/Use of elevator	□	□
	□ Transportation*	□	□
	□ Breaks (e.g. snack, bathroom, etc.)	□	□
	□ Additional time for class transition	□	□
	□ Other (please specify)	□	□

*Schools must obtain Cluster Health Liaison approval for paraprofessional and Office of Pupil Transportation approval for transportation

REQUEST FOR SECTION 504 ACCOMMODATIONS –OFFICE OF SCHOOL HEALTH- SCHOOL YEAR 2014-2015

PART 2A: PHYSICIAN REVIEW - To be completed by the student's physician

Physician Information

DATE completed by physician:		Physician Name:		NYS Registration #:	
		Office Address:		NPI #:	
		City / Zip Code:		Medicaid #:	
		Telephone:		Fax:	

Student Information

Name:	
DOB:	

Medical Diagnosis/Disability/ICD-9/DSM-V Code: _____

ATS Codes:

□ AD – Attention Deficit/Hyperactivity/Conduct	□ CV – Cardiovascular/Syncope	□ MO – Mobility Impairment
□ AL – Allergy/Food/Medication	□ DI – Diabetes/Glycogen Storage	□ NU – Neuro/Epilepsy/Seizures
□ AS – Asthma/Airway Disease	□ EA – Ear/Hearing	□ SK – Skin Disorder
□ BL – Anemia/Blood Disorders	□ EY – Eye/Vision	□ Other
□ CA – Cancer	□ GI - Gastrointestinal	

Describe how the diagnosis/condition affects the student's educational performance and which accommodations are recommended to address the student's needs:
** For transportation and paraprofessional requests, describe how the condition affects the student's ability to take transportation and/or the student's need for a paraprofessional.*

PART 2B: PARENT CONSENT - To be completed by the student's parent/guardian prior to submitting to school 504 Coordinator

To determine whether your child is eligible for accommodations under Section 504 of The Rehabilitation Act of 1973, a school-based 504 team will convene to review your child's records – including the physician's statement above (if applicable), classroom observations and assignments, assessment data, and other information. If your child is eligible to receive accommodations, a 504 Plan will be developed with your input and consent. The 504 Plan may be reviewed at any time, but at a minimum must be reauthorized annually.

By signing this form, you are giving consent to the 504 team to review your child's records and take the necessary steps to determine whether your child is eligible to receive accommodations. You also acknowledge that you have provided full and complete information to the best of your ability and understand that the New York City Department of Education (DOE), its agents, and its employees are relying on the accuracy of the information provided to determine whether and to what extent your child may receive accommodations under Section 504.

Date:	
Name of parent/guardian (print):	
Signature of parent/guardian:	
Daytime telephone number:	