

Section 504 Accommodation Plan

Student _____ Grade _____ Date _____

School _____ Teacher _____

YES ___ NO ___ The student has received an evaluation.

YES ___ NO ___ The student has a mental or physical impairment that substantially limits one or more

YES ___ NO ___ The impairment substantially affects the student's overall performance at school in regards to

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> seeing | <input type="checkbox"/> hearing | <input type="checkbox"/> doing manual tasks |
| <input type="checkbox"/> breathing | <input type="checkbox"/> walking | <input type="checkbox"/> speaking <input type="checkbox"/> caring for oneself |
| <input type="checkbox"/> writing | <input type="checkbox"/> learning | <input type="checkbox"/> working <input type="checkbox"/> showing troubling behavior |
| <input type="checkbox"/> breathing | <input type="checkbox"/> sleeping | <input type="checkbox"/> standing <input type="checkbox"/> lifting |
| <input type="checkbox"/> reading | <input type="checkbox"/> concentrating | <input type="checkbox"/> thinking <input type="checkbox"/> communicating |
| <input type="checkbox"/> helping | <input type="checkbox"/> eating | <input type="checkbox"/> bending <input type="checkbox"/> operation of a bodily function |
| <input type="checkbox"/> other | | |

Is this student identified to receive a 504 Accommodation Plan? _____

Describe what evaluation data was used; Describe this student's circumstances and its educational impact in more detail (that is, document the basis for the 504 Plan):

The case manager for this Section 504 Plan will be: _____

Date of Meeting & Initial Plan: _____

Annual Review scheduled for: _____

List each need in order of priority and describe specifically how it is to be met.

Specific Need (How does the impairment impact the student's education and what is needed to eliminate the restriction?)	Accommodations
	Special Materials or Training Needed – Who, How, and When?
	Who will Implement the Accommodations
	Criteria for Evaluating Success
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Section 504 Plan Team:

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

PARENT/GUARDIAN:

I, _____, as this student's parent/guardian,

☐ give ☐ do not give permission for my child to receive the accommodations described.

Signed: _____ Date: _____