**Section 504 Parent Referral**

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| Student Name: | | |  | | | | | Date of Birth: | | |  | Referral Date: | |  | |
| Student Number: | | | |  | | School: |  | | | | | | Grade: | |  |
| Please state the nature of your concern(s): Physical  Academic  Social/Emotional  Behavioral  Medical  Other: | | | | | | | | | | | | | | | |
| Explanation of concerns: | | | | | | | | | | | | | | | | |
| Major life activity that may be limited: Caring for Self  Hearing  Working  Performing Manual Tasks  Speaking  Reading  Walking  Breathing  Concentrating  Seeing  Learning  Thinking  Communicating  Eating  Sleeping  Standing  Other (Be specific) | | | | | | | | | | | | | | | | |
| Please describe and supporting observations and/or information. Attach any additional documentation that supports the student’s disability. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Please describe any interventions/accommodations that have been tried at home and/or at school. | | | | | | | | | | | | | | | | |
| Yes | No | | | | Does your student have any diagnosis? | | | | | | | | | | | |
| Yes | No | | | | Does your student have a Health Care Plan with Canyons School District? | | | | | | | | | | | |
| Person Making Referral | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | Title: |  | | | | | | |
| Signature: | |  | | | | | | | Date: |  | | | | | | |

# Parent Notice and Consent for Evaluation

Upon receipt of this referral, the School 504 Coordinator will form a team to evaluate your student. Members of the evaluation team will collect and review information to determine whether your student has a qualifying disability. Your student’s teacher(s), school’s counselor, school psychologist, and other staff members may be involved in observations, assessments, and other data collection activities.

We are requesting your consent to conduct this evaluation to determine whether he/she has a qualifying disability under Section 504 and to provide necessary accommodations should he/she qualify. This evaluation may include review of any or all of the following for the purpose of identification and services under Section 504, as well as the administration of additional evaluation/assessment procedures as indicated.

* Grades
* Parent Report
* Individual Achievement Tests
* School Records
* Medical Reports
* Other Tests
* Work Samples
* Classroom Teacher(s) Report

Section 504 provides you with specific rights concerning this evaluation process, which are designed to keep you fully informed concerning decisions about your student. These rights are summarized in the **Section 504 Parent Information, Public Notice and Grievance Procedure** document.

If you consent to the evaluation procedure described above, please sign and return to the school this form along with any additional information (e.g., medical reports, list of medications, parent reports, etc.) which may assist the Section 504 Team in their evaluation. You will be invited to attend a Section 504 eligibility meeting to discuss your student’s evaluation.

**I hereby give my written consent to have my student evaluated for possible Section 504 eligibility.**

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| --- | --- | --- | --- | --- |
| Parent/Legal Guardian Name: | |  | | |
| Signature: |  | | Date: |  |