PROGRAMS FOR STUDENTS WITH DISABILITIES EXHIBIT

504 REFERRAL FORM

Date of Referral: ______________________________

STUDENT INFORMATION:

Student's Name: ______________________________ Date of Birth: ____________

Grade: ____________________

Address: ______________________________________

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Home Phone: ______________________________________ -

PARENT/GUARDIAN INFORMATION:

Mother : ________________________
If different from student:
Address: ________________________
____
Phone: ________________________
Work Phone: ______________________

Father: ________________________
If different from student:
Address: ________________________
____
Phone: ________________________
Work Phone: ______________________

Emergency Contact Name & Phone: ____

REASONS FOR REFERRAL:

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<u>PARENT APPROVAL (to be completed by person making this referral)</u>

Parent **MUST** be contacted prior to this referral.
Parent comments:

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COMMENTS: Please describe attempts to remediate the student's performance within the current education program prior to the referral, and provide any specific information related to any areas checked on page 2. (i.e. identify changes made to classroom environment, interventions provided, etc.)

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EVALUATIONS REQUESTED:

□ Speech Evaluation:
Language Impairment:

_______ Articulation ____Expression______ Processing______________________
Written

□ Occupational Therapy Evaluation:

_______ Handwriting __________ Using Scissors__________________________
Posture
_______ Toileting Concerns ___________ Visual Limitations______________________
Weakness in hands
_______ Managing Clothing fasteners _______ Other: _______________

□ Physical Therapy Evaluation:

___________ Gait _______ Muscle Strength __ Balance
_______ Coordination ___________ Clumsiness ______ Difficulties in PE

□ Other: ____

____ ___________________________
Signature of § 504 Accommodation Officer Date
Theda Wilfore

Adoption date: April 17, 2007