RESET PRINT

Chino Valley Unified School District
Student Support Services

Section 504

REFERRAL AND REQUEST FOR SECTION 504 EVALUATION

Date of 504 Plan Meeting _____

Student's Name	Date of Birth	School Year
School	Perm ID #	Grade

Parent/Guardian _____

Home Address _____
City, State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Email Address _____

STUDENT NEED/AREA OF CONCERN

(It is MANDATORY that all questions below are answered)

What is the student's physical or mental impairment that substantially limits a major life activity?

What major life activity is substantially limited? (check all that apply)

- ☐ caring for one's self
- ☐ performing manual tasks
- ☐ walking
- ☐ seeing
- ☐ hearing
- ☐ speaking
- ☐ breathing
- ☐ learning
- ☐ working
- ☐ Other (specify):

Are there any current medical records, outside agency reports, prior school evaluations, etc., that would assist the team in evaluating the student? Please list and attach.

Has the student ever been evaluated for special education services? ☐ Yes ☐ No

If yes, indicate when _____

Person making the request _____ Relationship _____

PARENT ACKNOWLEDGEMENT – to have the above-named student evaluated and data collected for possible eligibility under Section 504.

Acknowledgement (check one) ☐ I consent ☐ I do not consent

Parent/Guardian Signature _____ Date _____

Return this form to the School Section 504 Coordinator. Attach any supportive documentation.

FOR OFFICE USE ONLY

Received By _____ Date Received _____