Referral for Section 504 Evaluation

Any person who believes a student has a disability that substantially limits one or more major life activity may refer a student for consideration for a Section 504 evaluation.

Referred By: _____ **Date:** _____

School Personnel Receiving Referral: _____ **Date Received:** _____

Filled out by School Filled out by School

Student's Name (Last) (First) (Middle)	**Grade**	**Age**	**Date of Birth**
School	**Student's Counselor**		
Parent/Guardian (1)	**Parent/Guardian (2)**		
Phone (1) **Cell:** **Work:**	**Phone (2)** **Cell:** **Work:**		
Primary Address (Number and Street/Apt.) (City) (State) (Zip Code)			

1. **What are your specific concerns about the student's performance?**

Academic:

Behavioral:

2. What interventions have been tried to help the student? What were the results?
3. What other challenges, concerns, or observations would you like to share?

Referring Party – check appropriate box(es)

☐ Parent/Guardian ☐ Teacher ☐ Medical or psychologist report

☐ Educational assessment ☐ Student Support Team Referral

☐ Other _____

Specific Reason for Referral – check appropriate box(es)

☐ Academics ☐ Behavioral ☐ Health ☐ Hearing ☐ Physical

☐ Social/Emotional ☐ Speech/Language ☐ Vision ☐ Work Habits

☐ Other _____

Educational History – check appropriate box(es)

☐ RTI Reading ☐ RTI Math ☐ Speech ☐ Special Education

☐ Support Team ☐ EL Support ☐ Previous 504 Plan

☐ Other _____