REQUEST FOR SECTION 504 ACCOMMODATIONS –OFFICE OF SCHOOL HEALTH- SCHOOL YEAR 2015-2016

PART 1: REQUEST FOR SECTION 504 EDUCATION ACCOMMODATIONS- To be completed by individual requesting accommodations. Submit to school 504 Coordinator

Date submitted to 504 Coordinator:		DBN:		School Name:	
Name of person submitting request:		Student Name:		Student DOB:	
Relationship to student:		Student ID #:		Grade/Class:	

Describe the concern below and how it affects the student's educational performance:

Indicate accommodations requested based on the concern above. Please consult the school-based 504 Coordinator with any questions.

Request for Educational Accommodation(s) *Check all requested:*		***For school use only***	
		Approve	**Deny**
Testing Accommodations	□ Test schedule/administration time (e.g. extended time, etc.)	□	□
	□ Test setting/location	□	□
	□ Method of presentation/Directions/Assistive Technology	□	□
	□ Method of test response/content support	□	□
	□ Other (please specify)	□	□
Classroom / Curriculum Accommodations	□ Class schedule/use of time	□	□
	□ Class activities setting	□	□
	□ Method of presentation/Directions/Assistive Technology	□	□
	□ Method of class activities response/Content Support	□	□
	□ Other (please specify)	□	□
Academic Supports and Services	□ Paraprofessional services*	□	□
	□ Safety Net *(high school only)*	□	□
	□ Other (please specify)	□	□
Scheduling / Other (?)*	□ Barrier-free site/Use of elevator	□	□
	□ Breaks (e.g. snack, bathroom, etc.)	□	□
	□ Additional time for class transition	□	□
	□ Other (please specify)	□	□

*A separate transportation form must be used for specialized transportation accommodations.

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PART 2A: PHYSICIAN REVIEW - To be completed by the student's Health Care Practitioner

Student Information

Name:	
DOB:	

Medical Diagnosis/Disability/ICD-Code/DSM-V Code: _____

Codes:

□ AD – Attention Deficit/Hyperactivity/Conduct	□ CV – Cardiovascular/Syncope	□ MO – Mobility Impairment
□ AL – Allergy/Food/Medication	□ DI – Diabetes/Glycogen Storage	□ NU – Neuro/Epilepsy/Seizures
□ AS – Asthma/Airway Disease	□ EA – Ear/Hearing	□ SK – Skin Disorder
□ BL – Anemia/Blood Disorders	□ EY – Eye/Vision	□ Other
□ CA – Cancer	□ GI - Gastrointestinal	

Describe how the diagnosis/condition affects the student's educational performance and which accommodations are recommended to address the student's needs:
** For and paraprofessional requests, describe how the condition affects the student's need for a paraprofessional.*

Health Care Practitioner Information

DATE completed by physician: _____

Physician Name:		NYS License #:	
Signature:		NPI #:	
Office Address:		Medicaid #:	
City / Zip Code:		Fax:	
Telephone:			

PART 2B: PARENT CONSENT - To be completed by the student's parent/guardian prior to submitting to school 504 Coordinator

To determine whether your child is eligible for accommodations under Section 504 of The Rehabilitation Act of 1973, a school-based 504 team will convene to review your child's records – including the physician's statement above (if applicable), classroom observations and assignments, assessment data, and other information. If your child is eligible to receive accommodations, a 504 Plan will be developed with your input and consent. The 504 Plan may be reviewed at any time, but at a minimum must be reauthorized annually.

By signing this form, you are giving consent to the 504 team to review your child's records and take the necessary steps to determine whether your child is eligible to receive accommodations. You also acknowledge that you have provided full and complete information to the best of your ability and understand that the Office of School Health (OSH), New York City Department of Education (DOE), their agents, and their employees are relying on the accuracy of the information provided to determine whether and to what extent your child may receive accommodations under Section 504. Additionally, you hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to your child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to your child.

Date:	
Name of parent/guardian (print):	
Signature of parent/guardian:	
Daytime telephone number:	