Attachments ☐ Yes ☐ No

§504 ACCOMMODATION PLAN

Student Name ________________________________ **OSIS** ______-_______-_______ **DOB** ___________

School _________________________ **School §504 Coord.** ______________________________________

Physical or Mental Impairment(s) ____

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Team Members: ____

____ **Date of Meeting:** ________________

1. Specific accommodations to be given to the student (Identify the staff members responsible for monitoring their provision) (If extra pages are necessary, please note below and check above for attachments).

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2. Student Responsibilities*

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3. Parent/Guardian Responsibilities*

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RECOMMENDED START DATE FOR ACCOMMODATIONS:_______________________________________

PARENT/GUARDIAN CONSENT

I have received notice of my procedural due process rights and understand that I have a right to contest the decisions made by the §504 Assessment Team contained in this §504 Accommodation Plan. I understand that no accommodations will be provided until I return this signed consent to the School §504 Coordinator.

By signing, I agree with the Accommodation Plan as written above and consent to the provision of accommodations to my child as recommended by the §504 Assessment Team.

____ ________________________

Signature of Parent/Guardian Date