**Section 504 Referral Form (Parent/Guardian/Adult Student)**

*This form is to be completed by a parent, guardian or adult student that suspects that the student has a disability.*

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_

Name of Person Completing this Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What are the student’s strengths?

2. What are your concerns about the student?

3. Does the student have a known physical or mental impairment? ☐ Yes ☐ No

 If yes, please specify and provide supporting documentation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Does the student have special health needs (i.e. allergy, asthma, diabetes, etc.)?

☐ Yes ☐ No If yes, please specify and provide supporting documentation:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please check below any formal supports/services that the student receives outside of school?

☐ Counseling ☐ Speech Therapy

☐ Tutoring ☐ Tutoring

☐ Medical Intervention ☐ Psychiatric Intervention

☐ Occupational Therapy ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Physical Therapy

6. Please check below any formal assessments or medical reports that have been completed and provide copies of those documents:

☐ Medical Report ☐ Vision Assessment

☐ Occupational Therapy Assessment ☐ Hearing Assessment

☐ Physical Therapy Assessment ☐ Psychiatric Assessment

☐ Psychological Assessment ☐ Speech and Language Assessment

☐ Educational Assessments ☐ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Staff Member Receiving Referral: Date of Receipt: