Section 504 Referral Form

Name: Date of Birth:
School: Age:
Date of Plan: Grade:

Statement of Suspected Section 504 Disability(s):

1. **Nature of the Concern (attach additional sheets as necessary):**

Check the suspected physical or mental impairment:

☐ Asthma	☐ Dyslexia	☐ Muscular Dystrophy
☐ Attention Deficit disorder/ADHD	☐ Emergent Allergy	☐ Orthopedic Impairment
☐ Brain Injury	☐ Emotional Illness	☐ Recovering Chemically Dependent
☐ Cancer	☐ Hearing Impairment	☐ Seizure Disorder (Epilepsy)
☐ Cerebral Palsy	☐ Minimal Brain Dysfunction	☐ Speech Impairment
☐ Development Aphasia	☐ Multiple Sclerosis	☐ Visual Impairment
☐ Diabetes	☐ Other: _____	

Please state any evaluative Data Source(s) supporting the diagnosis:

*Identify any **major life activities** that are limited*
(Note: this list is not exhaustive)

☐ Bending	☐ Reading
☐ Breathing	☐ Seeing
☐ Caring for one's self	☐ Sleeping
☐ Communicating	☐ Speaking
☐ Concentrating	☐ Standing
☐ Eating	☐ Thinking
☐ Hearing	☐ Walking
☐ Learning	☐ Working
☐ Lifting	☐ Other:
☐ Perform manual tasks	

*Identify any **major bodily functions** that are limited*
(Note: this list is not exhaustive)

☐ Bladder	☐ Reproduction
☐ Bowel	☐ Respiratory System
☐ Brain	☐ Other:
☐ Circulatory/ Cardiovascular System	_____
☐ Digestive System	
☐ Endocrine System	
☐ Immune System	
☐ Neurological System	
☐ Normal Cell Growth	

How is the major life activity limited?

How is the major bodily function limited?

1. **Please describe any interventions that have been tried at home or at school:**

2. **For School Staff:** If the major life activity which is effected by the suspected disability is academic, please attach a copy of the student's most recent grades and/or standardized test scores.
3. **For Parents/Guardian:** Please attach any medical documentation, psychological evaluations or other information which you would like the 504 team to consider and which you believe supports the student having a physical or mental impairment which substantially limits one or more major life functions.

Signature of person making the referral _____ Title _____ Date of referral: _____