

## PARENT/GUARDIAN NOTICE OF SECTION 504 CONFERENCE

Dear: –

Date: \_

You are cordially requested to attend a Section 504 conference regarding:

Student: \_\_\_\_\_

Date of Birth: \_

School: \_\_\_\_\_

Grade: \_

<b>Date of Conference:</b> _____ <b>Time:</b> _____ <b>Conference Location:</b> _____
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### Purpose of Conference:

- Consider possible eligibility for and/or provision of services under Section 504 of the *Rehabilitation Act of 1973*
- Develop a Section 504 Plan for your student
- Review eligibility for and/or services being provided under Section 504 of the *Rehabilitation Act of 1973*
- Review and revise your student's existing Section 504 Plan
- Conduct a manifestation determination review
- Other: \_

### Participants:

You have the right to bring other individuals, at your discretion, to this conference. Please notify \_ as soon as possible, if you are in need of an interpreter or translator.

Enclosed with this notice is a copy of your procedural safeguards under Section 504. If you have any questions please contact:

\_\_\_\_\_ at .

## CONFERENCE ATTENDANCE SHEET

STUDENT'S NAME: \_

STUDENT'S DATE OF BIRTH: \_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Location: \_

**Purpose of Conference:**

- Consider possible eligibility for and/or provision of services under Section 504 of the *Rehabilitation Act of 1973*
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- Conduct a manifestation determination review
- Other: \_

Names of Participants	Roles of Participants	Signature if in Attendance

## PARENT GUARDIAN CONSENT FOR SECTION 504 EVALUATION

Student:	_____	Date:	_____
School:	_____	Grade:	__ Date of Birth: _____
Parent/Guardian:	_____	Home:	_____
Address:	_____	Work:	_____
Parent/Guardian:	_____	Home:	_____
Address:	_____	Work:	_____

Section 504 of the *Rehabilitation Act of 1973* prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. Students who are covered by 504 are those who: 1) have a physical or mental impairment, which substantially limits one or more major life activities and results in a need for reasonable accommodations and/or related services, 2) have a record of such impairment or 3) are regarded as having such impairment.

### Step One: Explanation and Purpose of an Evaluation

Each school district shall ensure that a full and individual evaluation is conducted for each child being considered or reconsidered for 504 services and related services.

The purposes of an evaluation may be to determine:

- Whether the child has, or continues to have, a mental or physical impairment;
- Whether the mental or physical impairment substantially limits a major life activity;
- Whether the child needs, or continues to need, reasonable accommodations and/or special education and related services;
- The present levels of performance and educational needs of the child; and/or
- Whether any additions or modifications to the child's 504 Student Plan are needed.

### Step Two: Check the Major Life Activity that May Be Affected:

- |                                   |                                   |  |                                    |   |                                   |                                  |
|-----------------------------------|-----------------------------------|--|------------------------------------|---|-----------------------------------|----------------------------------|
| <input type="checkbox"/> seeing   | <input type="checkbox"/> hearing  | <input type="checkbox"/> caring for one's self | <input type="checkbox"/> breathing | <input type="checkbox"/> eating                                   | <input type="checkbox"/> sleeping | <input type="checkbox"/> lifting |
| <input type="checkbox"/> walking  | <input type="checkbox"/> learning | <input type="checkbox"/> communicating         | <input type="checkbox"/> working   | <input type="checkbox"/> performing manual tasks                  |                                   |                                  |
| <input type="checkbox"/> speaking | <input type="checkbox"/> thinking | <input type="checkbox"/> concentrating         | <input type="checkbox"/> reading   | <input type="checkbox"/> the operation of a major bodily function |                                   |                                  |
| <input type="checkbox"/> standing | <input type="checkbox"/> bending  | <input type="checkbox"/> other (specify) _     |                                    |   |                                   |                                  |

### Step Three: Sources of Evaluation Information

- |   |   |
|---|---|
| <input type="checkbox"/> medical reports/health information       | <input type="checkbox"/> motor assessments                |
| <input type="checkbox"/> adaptive behavior scales/behavior scales | <input type="checkbox"/> teacher/psychologist observation |
| <input type="checkbox"/> achievement tests                        | <input type="checkbox"/> discipline/attendance records    |
| <input type="checkbox"/> cognitive assessments                    | <input type="checkbox"/> student progress reports/grades  |
| <input type="checkbox"/> language surveys/assessments             | <input type="checkbox"/> functional behavior assessment   |
| <input type="checkbox"/> parent input                             | <input type="checkbox"/> other (specify): _               |

### Step Four: Parental Agreement

I understand my rights as explained to me and contained in the Parents Rights in Brief which I have received and reviewed. In addition, I understand the nature and scope of the evaluation to be completed. Upon completion of my child's evaluation, a conference will be scheduled to discuss the findings and determine my child's eligibility for 504 services and related services.

I consent                       I do not consent                      to an evaluation of my child

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

## SECTION 504 STUDENT PLAN

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Date of Meeting: \_\_\_\_\_  
Case Manager: \_\_\_\_\_ Next Review/Reassessment Date: \_\_\_\_\_

**1. Describe the student's mental and/or physical impairment:**

**2. Describe how the mental or physical impairment substantially limits a major life activity:**

**3. Describe the services/accommodations that are necessary:**

**4. State and District-Wide Assessments: (Specify needed accommodations, if any):**

**5. Additional Comments:**

**6. Person responsible for overseeing and monitoring the plan:** \_\_\_\_\_

**Participants**



*PARCC Accessibility Features and Accommodations for Students  
Addendum to IEP, Section 504, or ELE Plan*

STUDENT'S NAME: \_

STUDENT'S DATE OF BIRTH: \_

Accessibility features and accommodations available to the student are dependent upon the date and technology platform of the assessments.

Additional Accommodations

**Student Name:**

**Date of Meeting:**

**SECTION 504 STUDENT PLAN  
ADDITIONAL NOTES/INFORMATION**

A large, empty rectangular box with a thin black border, intended for additional notes or information.

## SECTION 504 CONFERENCE SUMMARY

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Date of Meeting: \_\_\_\_\_  
Case Manager: \_\_\_\_\_ Next Review/Reassessment Date: \_\_\_\_\_

**Purpose of Conference:**

- Consider possible eligibility for and/or provision of services under Section 504 of the *Rehabilitation Act of 1973*
- Develop a Section 504 Plan for your student
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- Review and revise your student's existing Section 504 Plan
- Conduct a manifestation determination review
- Other: \_\_\_\_\_

**I. Sources of Data:**

- |   |   |
|---|---|
| <input type="checkbox"/> medical reports/health information       | <input type="checkbox"/> motor assessments                |
| <input type="checkbox"/> adaptive behavior scales/behavior scales | <input type="checkbox"/> teacher/psychologist observation |
| <input type="checkbox"/> achievement tests                        | <input type="checkbox"/> discipline/attendance records    |
| <input type="checkbox"/> cognitive assessments                    | <input type="checkbox"/> student progress reports/grades  |
| <input type="checkbox"/> language surveys/assessments             | <input type="checkbox"/> functional behavior assessment   |
| <input type="checkbox"/> parent input                             | <input type="checkbox"/> other (specify): _____           |

**A. Is there documented evidence of a physical and/or mental impairment?**

- Yes       No

**B. Is a major life activity substantially limited by the physical or mental impairment?**

- Yes       No

If yes, please check the major life activity(s) that is/are substantially limited.

- |                                   |                                   |  |                                    |   |                                   |                                  |
|-----------------------------------|-----------------------------------|--|------------------------------------|---|-----------------------------------|----------------------------------|
| <input type="checkbox"/> seeing   | <input type="checkbox"/> hearing  | <input type="checkbox"/> caring for one's self | <input type="checkbox"/> breathing | <input type="checkbox"/> eating                                   | <input type="checkbox"/> sleeping | <input type="checkbox"/> lifting |
| <input type="checkbox"/> walking  | <input type="checkbox"/> learning | <input type="checkbox"/> communicating         | <input type="checkbox"/> working   | <input type="checkbox"/> performing manual tasks                  |                                   |                                  |
| <input type="checkbox"/> speaking | <input type="checkbox"/> thinking | <input type="checkbox"/> concentrating         | <input type="checkbox"/> reading   | <input type="checkbox"/> the operation of a major bodily function |                                   |                                  |
| <input type="checkbox"/> standing | <input type="checkbox"/> bending  | <input type="checkbox"/> other (specify) _____ |                                    |   |                                   |                                  |

**C. If the answer to B was "no," is the impairment substantially limiting when active (if the condition is episodic or in remission) or being mitigated by other factors (e.g. medication)?**

- Yes     No     N/A

If Yes, please specify factors considered:

**D. Is the student considered a qualified individual with a disability under Section 504 of the Rehabilitation Act? (Team answered, "yes" to questions A & B or A & C)?**

- Yes     No

**II. Summary of other points of discussion/recommendations (if applicable):**

## SECTION 504 CONFERENCE SUMMARY

Student: \_\_\_\_\_ Grade: \_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Date of Meeting: \_\_\_\_\_  
Case Manager: \_\_\_\_\_ Next Review/Reassessment Date: \_\_\_\_\_

### Participants:



## **Parent/Student Rights**

### **Section 504 of the Rehabilitation Act of 1973**

You have the right to:

1. Have your child take part in, and receive a free and appropriate education and receive benefits from public education programs without discrimination because of his/her disability;
2. Have the school district advise you of your rights and procedural safeguards under Section 504 in an understandable language;
3. Receive notice with respect to identification, evaluation, or placement of your child;
4. Have your child receive a free appropriate public education. This includes the right to be educated with nondisabled students to the maximum extent appropriate in the least restrictive environment. It also includes the right to have the school district make reasonable accommodations to allow your child an equal opportunity to participate in school-related activities;
5. Have your child educated in facilities and receive services comparable to those provided nondisabled students;
6. Have your child receive an individualized evaluation and receive appropriate educational services and/or accommodations in the least restrictive environment if s/he is found to be eligible under the Section 504 of the Rehabilitation Act;
7. Have evaluation, educational, and placement decisions made based upon a variety of information sources, and by person who know the student, the evaluation data, and placement options;
8. Have your child be given an equal opportunity to participate in nonacademic and extracurricular activities offered by the district;
9. Examine all relevant records relating to decisions regarding your child's identification evaluation, educational program and placement, obtain copies of educational records at a reasonable cost unless the fee would effectively deny you access to the records.
10. Receive a response from the school district to reasonable requests for explanations and interpretations of your child's records;
11. Request an amendment(s) of your child's educational records if you believe that they are inaccurate, misleading or otherwise in violation of the privacy or other rights of your child. If the school district refuses your request for amendment, it shall notify you within a reasonable time, and advise you of the right to a hearing consistent with the procedures in the Illinois School Student Records Act;
12. File a grievance under the District's Uniform Grievance Procedure with the district hearing officers;
13. Request an impartial due process hearing related to decisions or actions regarding your child's identification, evaluation, educational program or placement. You and the student may take part in the hearing and have an attorney represent you at your own expense. The impartial Hearing Officer will be selected by the district.
14. File a complaint with the Office for Civil Rights of the United States Department of Education alleging a violation of your rights under Section 504.

## Parent/Guardian Receipt of Section 504 Procedural Safeguards

Dear \_

Section 504 of the Rehabilitation Act requires that school districts document that parents have been provided and understand the Parent/Student rights in Identification, Evaluation and Placement pursuant to Section 504 of the *Rehabilitation Act*.

The attached Parent/Student Rights is designed to provide an explanation of the important information regarding the safeguards to which the parent/guardian and child are entitled.

Please sign and date below that you are in receipt of your Parent/Student Rights.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Name:  DOB:

**SUMMARY OF PARENT /GUARDIAN CONTACT**

1. School Person making contact: \_

Campus/School: \_ School Year \_\_\_\_\_ Date of Contact:

Method of Contact:  eMail  US Mail  Student  In person  Phone

Interpreter needed: \_\_\_\_\_ Language: \_\_\_\_\_

Results/Outcome for method of contact:

	Academic	Behavioral	Language/ Communication	Physical	Social
School Concern:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent Concern:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Summary of Discussion w/parent/guardian: