504 ACCOMMODATION PLAN

Student's Name: ______________________ DOB: ______________ Age: ________ Sex: ________

School: ______________________ Grade/Subject: ______________________

Review Date(s): ______________________ ______________ ______________

Date: ______________ Case Manager: ______________________

Parent Notification: by ______________________ ☒ Phone ☐ Personal contact Date: ______________

AREA(S) OF STRENGTH:

AREA(S) of DIFFICULTY	ACCOMMODATIONS (Refer to 504 Accommodation)	Starting Date	Person Responsible	OUTCOME

ELIGIBILITY FOR 504 ASSISTANCE
(check applicable areas):

- ☐ caring for one's self
- ☐ performing manual tasks
- ☐ walking
- ☐ seeing
- ☐ hearing
- ☐ speaking
- ☐ breathing
- ☐ learning
- ☐ working
- ☐ other: ____________

________________________________ disability

________________________________type of documentation

SERVICES REQUIRED

Regular Class x________________________________

School Nurse ________________________________

Aide ________________________________

Guidance Counselor ________________________________

____________ ________________________________

____________ ________________________________

____________ ________________________________

____________ ________________________________

____________ ________________________________

Describe areas of need/action to be taken	Team Members	Position	Date
			Revised 3/1/01