Indian Prairie School District #204
Crouse Education Center
780 Shoreline Drive
Aurora, IL 60504

Section 504 Referral

Student Name: ____________________________**Student ID:** _______________ **DOB:**______

Grade: _________ **Referral Date:** ______________ **School:** _________________________

Referred by: ___________________________

Reason for Referral (attach additional pages if necessary)

____

____

____

____

Attendance

Is this student enrolled in school? ___YES___NO - If no, explain _________________________

____

____

This student has been absent ____ days out of ____ school days last school year.

Reason(s) ____

____

____

____

____

This student was absent _____ days out of ____ school days last school year.

Reason(s) ____

____

____

____

____

INDIAN PRAIRIE
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Student Grades

Overtime, this student's grades: (check appropriate answer)

___have become higher each year

___ stayed about the same each year

___ have become lower each year

___ dropped suddenly in ____ grade

___ data not available

Compared with most of the other students in this school, this student's grades: (check appropriate answer)

___ are better

___ are about the same

___ are worse

___ data not available

Has the student ever been retained? ___YES___NO – If YES, list grade level(s) where retention occurred and reason for retention(s) ____

____

____

____

____

____

Discipline Information (Attach copies of any behavioral plan or contract)

Identify the behaviors exhibited by the student (check all that apply)

___Poor attention and concentration

___Shift from one uncompleted task to another

___Often loses things necessary for tasks

___Interrupts or intrudes on others

___Excessively high/low activity level

___ Difficulty working with peers

___Difficulty following directions

___ Difficulty remaining seated

___Fidgets, squirms or seems restless

___ Confrontational/assaultive

___ Leaves class without permission

___ Brings inappropriate items to school

___ Other

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In response to these behaviors, what behavior management techniques have been attempted?

____

____

____

____

____

Results of these techniques:

____

____

____

____

____

Mitigating Measures (Identify any mitigating measures currently in use by the student or provided for student's benefit. Check all that apply)

___ Medication: ____

___ Medical supplies, equipment, or appliances: ______________________________________

___Low-vision devices (which do not include ordinary eyeglasses or contact lenses: ______________

___ Prosthetic including limbs and devices: ____

___Hearing aids and cochlear implants or other implantable hearing devices: __________________

___Mobility devices: ____

___Oxygen therapy equipment and supplies: ____

___Assistive technology: ____

___Reasonable accommodations (includes early intervention, RTI, differentiated instruction and informal help from teachers):____

___Auxiliary aids or services (includes health plans, emergency plans): ___________________________

___ Other: ____

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Health Information

Attach information relating to any doctor's order, diagnoses, or evaluation pertaining to disability (example, medical reports, psychological reports, ADD/ADHD diagnostic information, etc.)

Does student exhibit any signs of health or medical problems? ___YES___NO – If YES, explain

____

____

Is student receiving any medication at school? ___ YES ___NO – If YES, list medications _______________

____

____

Does the student require adaptive equipment or facility adaptation? ___ YES ___NO – If YES, attach list of needs.

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Parent/Guardian Consent for Evaluation

Student Name: ______________________ **Grade:** ______ **Date:** __________ **DOB:** __________

Parent/Guardian: ______________________________

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 special education and 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

The 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

☐ seeing ☐ hearing ☐ breathing ☐ caring for one's self
☐ eating ☐ sleeping ☐ lifting ☐ walking
☐ learning ☐ reading ☐ working ☐ performing manual tasks
☐ standing ☐ bending ☐ thinking ☐ communicating
☐ speaking ☐ concentrating ☐ the operation of a major bodily function
☐ other(specify): ______________________________

Step Three: Sources of Evaluation Information

☐ medical reports/health information
☐ teacher/psychologist observation
☐ achievement tests
☐ cognitive assessments
☐ language surveys/assessments
☐ motor assessments
☐ other(specify): ______________________________
☐ adaptive behavior scales/behavior scales
☐ discipline/attendance records
☐ student progress reports/grades
☐ functional behavior assessment
☐ parent input

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

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Notice of Conference

To: ______________________________ **Date:** __________

Re: (Student Name):a______________________________

Date of Conference: __________ **Time:** ______________________________

Location of Meeting: ______________________________

☐ Parent waived ten day notice. Parent initials ______ Date __a___a___
Comments:

Purpose of Conference:

☐ To consider possible eligibility for and/or provision of services and/or accommodations under Section 504 of the *Rehabilitation Act of 1973.*
☐ To review eligibility for and/or services and/or accommodations being provided under Section 504 of the *Rehabilitation Act of 1973.*
☐ Other:

Conference Participants (Title and Name):

______________________________ ______________________________

______________________________ ______________________________

You have the right to bring other individuals, at your discretion, to this conference. Please notify your student's counselor if you are in need of an interpreter or translator.

Enc.: Parent Rights in Brief

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Notice of Conference

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 Parents' Rights in Brief is designed to provide a brief explanation of the important information regarding the safeguards to which parents/guardians and children are entitled. A complete copy of the District's Section 504 Procedures and Procedural Safeguards is available at

____

Please sign and date below that you are in receipt of your Parents' Rights in Brief.

____ Parent/Guardian Signature

________________________ Date

PARENT/STUDENT RIGHTS

(Section 504 of the Rehabilitation Act of 1973)

The following is a description of the rights granted by federal law to students with handicaps. The intent of this law is to keep you fully informed concerning decisions about your child and to inform you of your rights if you disagree with any of these decisions. Please keep this explanation for future reference.

YOU HAVE THE RIGHT TO:

1. Have your child take part in, and receive benefits from public education programs without discrimination because of his/her disabling conditions;
2. Have the school district advise you of your rights under federal law;
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 students without disabilities to the maximum extent appropriate. It also includes opportunity to participate in school and school-related activities;
5. Have your child educated in facilities and receive services comparable to those provided students without disabilities;
6. Have your child receive special education and related services if he/she is found to be eligible under the Individuals with Disabilities Education Act (PL 101-476) or Section 504 of the Rehabilitation Act.
7. Have evaluation, educational, and placement decisions made based upon a variety of information sources and by persons 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;
10. Obtain copies of educational records at a reasonable cost unless the fee would effectively deny you access to the records;
11. A response from the school district to reasonable requests for explanations and interpretations of your child's records;
12. Request amendment of your child's educational records if there is reasonable cause to believe that they are inaccurate, misleading or otherwise in violation of the privacy rights of your child. If the school district refuses this request for amendment, it shall notify you within a reasonable time, and advise you of the right to a hearing.
13. Request mediation or a Section 504 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. Hearing requests must be made to the Director of Student Services, Michelle Gallo (Section 504 District Coordinator).
14. File a local grievance. A copy of the District 204 "Grievance Procedure" as it applies to Section 504 is available from the Section 504 District or Building Coordinator. Please call and a copy will be immediately sent to you.

The person in District #204 who is responsible for insuring that the district complies with Section 504 is Michelle Gallo, Director of Student Services. The telephone number is 630-375-3307.

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Eligibility Conference Summary

Student Name: ____________________ **Grade:** ______ **Date:** ________ **DOB:** ________

504 Coordinator: ______________________________

Next Review Date: ________ **Next Reassessment Date:** ________

Purpose of Conference:

☐ To consider possible eligibility for and/or provision of services and/or accommodations under Section 504 of the *Rehabilitation Act of 1973.*
☐ To review eligibility for and/or services and/or accommodations being provided under Section 504 of the *Rehabilitation Act of 1973.*
☐ Other:

I. Sources of Data:

☐ medical reports/health information
☐ adaptive behavior scales/behavior scales
☐ achievement tests
☐ cognitive assessments
☐ language surveys/assessments
☐ motor assessments
☐ teacher/psychologist observation
☐ discipline/attendance records
☐ student progress reports/grades
☐ functional behavior assessment
☐ parent input
☐ other (specify) ______________

A. Is there documented evidence of a physical and/or mental impairment?
☐ Yes ☐ No (if no, a 504 plan is not required)

B. Is a major life activity substantially limited by the physical or mental impairment?
☐ Yes ☐ No (if no, a 504 plan is not required)

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

☐ caring for one's self
☐ breathing
☐ seeing
☐ communicating
☐ thinking
☐ hearing
☐ the operation of a major bodily function
☐ speaking
☐ eating
☐ bending
☐ learning
☐ performing manual tasks
☐ sleeping
☐ other (specify): ______________
☐ lifting
☐ reading
☐ walking
☐ working
☐ standing
☐ concentrating

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

Conference Participants:

______________________ ______________________

______________________ ______________________

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Section 504 Plan

Student Name: ____________________ **Grade:** a______ **Date:** __________ **DOB:** __a______

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, and/or other supports that are necessary (including their frequency, location, and duration) and who will provide them:

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

5. Additional Comments:

6. Review Date: ____________

7. Triennial Reassessment Date: ____________

8. Person responsible for overseeing and monitoring the plan: ____________________

Participants:

____________________ ____________________

____________________ ____________________

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Conference Notes

Student Name: ______________________ **Grade:** ________ **Date:** ____________ **DOB:** __a__a______

Participants:

______________________________ ______________________________

______________________________ ______________________________

NOTES/SUMMARY:

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Accommodation Checklist

Student Name: ______a__________a a________a a______________a a__ **School Year:** ______

Teacher Name: ____ **Quarter:** ______

Course:a____

Listed below are the classroom accommodations on the 504 plan for the student identified above. Please complete this checklist weekly to document use of the listed accommodations in your classroom. Please provide additional notes when more information is necessary.

Form should be returned to: ______________________________

Key: Y = yes, used this week
O = offered, but not utilized by student
NN = not necessary this week
NA = not applicable in this class

Accommodation:	Specifics:	Week of:									

Signature: ____

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Conference Summary Report

Conference Date:

Student Identification Information

Student's Name: ____________ **DOB:** ________ **Gender:** ______
Address: ____________
Ethnicity: ____________
Student Phone: ____________ **Home Phone:** ____________
Parent/Guardian: ____________ **Work Phone:** ____________
Address: ____________
Other Parent/Guardian: ____________ **Other Parent Phone:** ____________ a a a a a a
Address: ____________
SIS Number: ____________ **Home School:** ____________
Current School Year: ____________ **Serving School:** ____________
Grade Placement: ____________ **Next Home School:** ____________
Next School Year: ____________ **Next Serving School:** ____________
Next Grade Placement: ____________ **Serving District:** ____________
Annual Review Due Date: ____________ **Resident District:** ____________

PARTICIPANTS

Signature indicates attendance.

Student	School Psychologist
Parent/Guardian	Nurse
Parent/Guardian	Social Worker
Principal	Other (specify)
Counselor	Other (specify)
General Education Teacher	Other (Specify)

Document the attempts made to arrange a mutually agreeable time to meet.
1. ____________ 2. ____________ 3. ____________

PARENTS' RIGHTS

Explanation of Parents' Rights was provided to/reviewed with the parent(s):(date) ________

(Parent/Guardian Initial): ________

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Medical Services Plan

Student Name: ______________________ **Grade:** ______ **DATE:** ________ **DOB:** ________

Parent/Guardian: ______________________ **Phone:** ________

Address: ______________________

Home School: ______________________

Serving School: ______________________

Teacher: ______________________

MEDICAL CONDITION (Example: Diabetes, Feeding Tube, etc):

ALLERGENS (Example: Food Allergies, Latex Gloves, etc):

Please check the following if appropriate:

- ☐ Diabetes
- ☐ Asthma
- ☐ Allergies
- ☐ Seizure Disorder

MEDICATION

Name of Medication: ______________________

Who Administers: ______________________

Time Administered: ________ **Dates (if appropriate):** ________

How to Administer:

Reason for Medicine:

Notes:

PROCEDURES

MEDICAL SERVICE PLAN (Include restrictions of movement, feeding, and other activities):

Provider: ______________________ **Minutes Per Week:** ________

MEDICAL EQUIPMENT USE AND CARE PLAN:

Contact Person For Equipment Maintenance: ______________________

EMERGENCY EVACUATION PLAN:

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Medical Services Plan

Training Provided On (Date): ____________ **Training Provided By:** ______________________________________

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Aurora, IL 60504

Parent/Guardian Consent for Initial Provision of Section 504 Aids and Services

Student's Name: ______a__a__a______ **Grade:** a______ **Date:** __________ **DOB:** __________

Dear ______________________________

At a recent conference your child was recommended for the initial provision of Section 504 aids and services and a Section 504 plan was developed. Before a school district may provide the aids and services described in your child's Section 504 plan, your informed written consent is required. Your consent is voluntary and you may revoke your consent at any time. If you revoke consent, it does not negate any action that occurred after the consent was given and before it was revoked.

CHECK ONE:

☐ I give consent

For the initial provision of the aids and services as indicated on my child's Section 504 plan. The proposed aids and services have been fully explained to me and are consistent with the Section 504 plan developed for my child.

I understand that my consent is voluntary. I understand that my consent is not required for continued Section 504 aids and services or for a change in the aids and services. At least annually, I will be given reasonable opportunity for comment on and input into my child's Section 504 plan.

I received a copy of the **Parents' Rights in Brief** which have been fully explained to me by school personnel, including the procedures for requesting an impartial hearing.

I understand that as soon as possible following development of the Section 504 plan, but not more than ten (10) calendar days, aids and services will be provided to my child in accordance with his/her Section 504 plan.

☐ I do not give consent

For aids and services indicated in the Section 504 plan.

I understand that the school district will not be in violation of the requirement to make available a free appropriate public education for my child if I refuse to give consent.

☐ I have received

- ☐ Copy of the Section 504 Eligibility Summary
- ☐ Copy of the Section 504 Plan
- ☐ Other

Date: __________ **Parent/Guardian Signature:** ______________________________

If you have any questions concerning this process or require additional information regarding your and your child's rights, please contact

Name: ____________________ **Title:** ____________________ **Phone:** __________

Sincerely, ______________________________
(Signature)

Name: ______________________________ **Title:** a a a a ______________________

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Functional Behavioral Assessment

Complete when gathering information about a student's behavior to determine the need for a Behavioral Intervention Plan. If used in developing a Behavioral Intervention Plan, the Functional Behavioral Assessment must be reviewed at a 504 meeting and should be attached to the 504 plan.

Student Name: ____________________ **Grade:** ________ **Date:** ____________ **DOB:** ____________

The Functional Behavioral Assessment must include data collected through direct observation of the target behavior. Attach documentation of data collection.

Participant/Title:

______________________________ ______________________________

______________________________ ______________________________

STUDENT STRENGTHS - Include a description of behavioral strengths (e.g., ignores inappropriate behaviors of peers, positive interactions with staff, accepts responsibility, etc.).

OPERATIONAL DEFINITION OF TARGET BEHAVIOR - Include a description of the frequency, duration and intensity of the behavior.

SETTING - Include a description of the setting in which the behavior occurs (e.g., physical setting, time of day, persons involved).

ANTECEDENTS - Include a description of the relevant events that preceded the target behavior.

CONSEQUENCES - Include a description of the result of the target behavior(e.g. removed from the classroom and did not complete assignment. What is the payoff for the student?).

ENVIRONMENTAL VARIABLES - Include a description of any environmental variables that may affect the behavior (e.g., medication, weather, sleep, diet, social factors).

HYPOTHESIS OF BEHAVIORAL FUNCTION - Include a hypothesis of the relationship between the behavior and the environment in which it occurs.

Is this behavior a ☐ Skill Deficit or a ☐ Performance Deficit

Skill Deficit: The student does not know how to perform the desired behavior.

Performance Deficit The student knows how to perform the desired behavior, but does not consistently do so.

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Behavior Intervention Plan

A functional assessment of behavior must be completed and attached prior to developing a Behavior Intervention Plan.

Complete when the Section 504 team has determined a Behavior Intervention Plan is needed.

Student Name: a a a a **Grade:** ________ **Date:** a a a a **DOB:** __________

Target Behavior(s):	Intervention(s) to be Implemented:	Procedure/schedule for evaluating effectiveness and person responsible:

Date of plan review: ____________________

Method of home/school communication: ____________________

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Manifestation Determination for Section 504 Students

A. Identifying information:

Student Name: ______________________ **Grade:** a______ **Date:** __________ **DOB:** __________

Date of Suspension: __________

B. Conference Participants:

______________________________ ______________________________

______________________________ ______________________________

C. Team review and determination:

1. What is the misconduct for which disciplinary action has been taken or is being considered?
   Comments:

2. The team has considered and reviewed the following relevant student information in terms of the misconduct subject to disciplinary action:

   Evaluation, diagnostic results or other relevant information, including student's most recent Section 504 evaluation and plan:
   ☐ Yes ☐ No

   Is there a behavior intervention plan as part of the student's 504 plan? ☐ Yes ☐ No

   (If NO, the building team will initiate a Functional Behavioral Assessment and when complete, will convene a meeting on __________ to develop a Behavior Intervention Plan to address the behavior.)

   Observation of the student: ☐ Yes ☐ No

   Comments

3. In determining if the misconduct was a manifestation of his/her disability, the Section 504 team must determine the following:
   (a) If the misconduct in question was caused by, or had a direct and substantial relationship to, the child's disability; or
   (b) If the misconduct in question was the direct result of the District's failure to implement the Section 504 Plan.

4. If the team determines the misconduct was not a manifestation of the child's disability, then the District's regular disciplinary procedures will apply

5. If the team determines that the misconduct was a manifestation of the child's disability
   (a) The team must conduct a Functional Behavioral Assessment and implement a behavior intervention plan (BIP) if this has not already been done prior to the current misconduct;
   (b) If a BIP has already been developed, review and modify it, as necessary, to address the misconduct in question; and
   (c) The team must review the student's current 504 plan and educational placement to determine if it remains appropriate. If the team believes that a significant change in placement may be necessary, the team must initiate a reevaluation of the student.

   Notes:

REQUEST FOR A SECTION 504 INFORMAL RESOLUTION

INSTRUCTIONS: This form has been developed to process requests for a Section 504 Informal Resolution. It is to be used in cases in which the parents wish to have an internal review of their concerns regarding the identification, evaluation, educational placement/programming for their child or believe the existing 504 Plan has not been implemented or believe their child has been subject to discrimination. The completed form must be given to the Assistant Superintendent of Student Services, at the District office at 780 Shoreline Drive, Aurora, Il or email it to christina_sepiol@ipsd204.org.

NAME OF STUDENT	STUDENT'S BIRTHDATE (Month/Day/Year)

PARENT/GUARDIANS' LANGUAGE/MODE OF COMMUNICATION

A BILINGUAL OR SIGN LANGUAGE INTERPRETER IS REQUESTED

× YES × NO IF YES, Specify language/mode of communication ____________________

NAME OF PARENT/GUARDIAN	TELEPHONE (Include Area Code)
ADDRESS (Street, City, State, Zip Code)	FAX (Include Area Code)
	E-MAIL
NAME OF THE SCHOOL STUDENT ATTENDS	GRADE

A DESCRIPTION OF THE ALLEGED ACTION(S) OR OMISSION(S) REGARDING:

A. THE STUDENT'S SECTION 504 IDENTIFICATION, EVALUATION, OR PROGRAM /PLACEMENT **OR**
B. THE IMPLEMENTATION OF AN EXISTING 504 PLAN **OR**
C. ACTIONS THAT ARE ALLEGED TO CONSTITUTE DISCRIMINATION.

(Include dates of alleged action(s) or omission(s), if known. Attach additional pages if necessary.)

A DESCRIPTION OF THE RESOLUTION OR ACTION YOU ARE SEEKING **(Attach additional pages if necessary.)**

Date Submitted to District

Signature of Parent/Guardian

REQUEST FOR AN IMPARTIAL SECTION 504 HEARING

INSTRUCTIONS: This form has been developed to process requests for an Impartial Section 504 Hearing. It is to be used in cases in which parents wish to have an impartial hearing officer review issues regarding the identification, evaluation, educational placement/programming for their child or believe the existing 504 Plan has not been implemented or believe their child has been subject to discrimination. The completed form must be given to the Assistant Superintendent of Student Services, at the District office at 780 Shoreline Drive, Aurora, Il or email it to christina_sepiol@ipsd204.org.

NAME OF STUDENT	STUDENT'S BIRTHDATE (Month/Day/Year)

PARENT/GUARDIANS' LANGUAGE/MODE OF COMMUNICATION

A BILINGUAL OR SIGN LANGUAGE INTERPRETER IS REQUESTED

× YES × NO IF YES, Specify language/mode of communication ______________________________

NAME OF PARENT/GUARDIAN	TELEPHONE (Include Area Code)
ADDRESS (Street, City, State, Zip Code)	FAX (Include Area Code)
	E-MAIL
NAME OF THE SCHOOL STUDENT ATTENDS	GRADE

A DESCRIPTION OF THE ALLEGED ACTION(S) OR OMISSION(S) REGARDING:

A. THE STUDENT'S SECTION 504 IDENTIFICATION, EVALUATION, OR PROGRAM /PLACEMENT **OR**

B. THE IMPLEMENTATION OF AN EXISTING 504 PLAN **OR**

C. ACTIONS THAT ARE ALLEGED TO CONSTITUTE DISCRIMINATION.

(Include dates of alleged action(s) or omission(s), if known. Attach additional pages if necessary.)

A DESCRIPTION OF THE RESOLUTION OR ACTION YOU ARE SEEKING **(Attach additional pages if necessary.)**

Date Submitted to District

Signature of Parent/Guardian

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504 Student Tracking

First/Middle Name: Test Test **Grade:** 3rd **Date:** 09/28/2018 **DOB:** 05/03/2009

- ☐ New Student/Enrolled
- ☐ Moved From District
- ☐ Initial Placement/Eligibility
- ☐ Does Not Qualify
- ☐ Update Student Data

Dropped, Moved, Enrolled Information

Date	Action	Reason	Receiving District

Conference Date: 09/28/2018

Student Identification Information

Student Name: Test, Test **DOB:** 05/03/2009

Ethnicity:

Student Phone: **Home Phone:**

Parent/Guardian: **Work Phone:**

Other Parent/Guardian: **Other Parent Phone:**

SIS Number: **Home School:** Welch Elementary School

Current School Year: **Next Home School:**

Grade Placement: 3rd **Resident District:** Indian Prairie School District #204

Next School Year: **Next Grade Placement:**

Annual Review Due Date: **Reevaluation Due Date:**

Date of Initial 504 Plan: