

Sargent Central Public School

504 Accommodations Plan

Student _____ Date _____

Case Manager _____

Explanation of 504 Eligibility

Check each area where special accommodations/services will help the student meet success at school.

- | | | |
|---|--|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Note Taking | <input type="checkbox"/> Seating |
| <input type="checkbox"/> Writing | <input type="checkbox"/> Organization | <input type="checkbox"/> Space |
| <input type="checkbox"/> Math | <input type="checkbox"/> Homework | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Assignment Completion | <input type="checkbox"/> Listening |
| <input type="checkbox"/> Vocabulary | <input type="checkbox"/> Test Taking | <input type="checkbox"/> Interpersonal Skills |
| <input type="checkbox"/> Physical Education | <input type="checkbox"/> Memory | <input type="checkbox"/> Assistive Devices |
| <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Time | |

Accommodations and Services

1. Area of Difficulty _____ (ex. Communication)

Accommodations _____

2. Area of Difficulty _____ (ex. Seating)

Accommodations _____

3. Area of Difficulty _____ (ex. Writing)

Accommodations _____

Permission of Mentioned Services

Duration of Accommodations: ____ / ____ / ____ to ____ / ____ / ____

Date of Review/Reassessment Date ____ / ____ / ____

I give permission for my child to receive the above-mentioned services.

Parent Signature Date

Section 504 Committee Member

504 Coordinator/Counselor High School Principal

Classroom Teacher Classroom Teacher

Classroom Teacher Classroom Teacher

Classroom Teacher Classroom Teacher

Classroom Teacher Classroom Teacher