Section 504 Suspected Disability Referral — Chagrin Falls Exempted Village Schools

CHILD'S NAME: _____ ID NUMBER: _____ DATE OF BIRTH: _____

CHILD'S INFORMATION

CHILD'S NAME: _____ ID NUMBER: _____ DATE OF BIRTH: _____

Please complete this form if you suspect that this student may have a physical or mental impairment that substantially limits one or more major life activities.

NATURE OF CONCERN (attach additional documentation if necessary)

1. Check the suspected physical or mental impairment.

☐ Allergy _____ ☐ Asthma ☐ Attention deficit disorder/ADHD ☐ Brain injury
☐ Cancer ☐ Cerebral Palsy ☐ Developmental aphasia ☐ Diabetes ☐ Dyslexia ☐ Emotional illness
☐ Epilepsy ☐ Hearing impairment ☐ Heart disease ☐ Minimal brain dysfunction ☐ Multiple sclerosis
☐ Muscular dystrophy ☐ Orthopedic impairment ☐ Recovering chemically dependent ☐ Seizures
☐ Speech impairment ☐ Visual impairment ☐ Other: _____

State any evaluative/data source supporting the suspected impairment.

2. Identify any major life activity(ies) and/or major bodily function(s) that are limited.

activities:

☐ Bending
☐ Breathing
☐ Caring for ones self
☐ Communicating
☐ Concentrating
☐ Eating
☐ Hearing
☐ Learning
☐ Lifting
☐ Performing manual tasks
☐ Reading
☐ Seeing
☐ Sleeping
☐ Speaking
☐ Standing
☐ Thinking
☐ Walking
☐ Working
☐ Other: _____

bodily functions:

☐ Bladder
☐ Bowel
☐ Brain
☐ Circulatory/Cardiovascular System
☐ Digestive system
☐ Endocrine system
☐ Immune system
☐ Neurological system
☐ Normal cell growth
☐ Respiratory system
☐ Reproduction
☐ Other: _____

3. Indicate how any major life activity(ies) and/or major bodily function(s) is/are substantially limited.

4. To date, what accommodations/modifications/interventions or special provisions have been made to assist the student?

_____ _____ _____
Signature of Person Making Referral Relationship to Student Date

The signature of the individual receiving this referral documents that a copy of this form and Section 504 Procedural Safeguards have been given or sent to the parent or guardian.

_____ _____ _____
Signature of Person Receiving Referral Title of Person Receiving Referral Date Received