504 Initial Referral

Student Name:		SIS:
DOB:	Grade:	School:

Student's disability/ impairment:

This impairment ***substantially limits one*** or more of the following major life activities:

☐ Learning (Reading, thinking, school work…)	☐ Medical – major bodily functions	☐ Self-care – (Eating, sleeping, toileting…..)
☐ Concentration	☐ Physical (Fine motor, writing, walking, standing, lifting, bending…)	☐ Communication – Seeing, hearing…)
☐ Social/Emotional	☐ Other:	

How are the above, checked major life activities substantially limiting the student in the educational setting?

Does the student have a current Ogden City School District Individualized Health Care Plan? ☐ Yes ☐ No

Does the student have a current Ogden City School District Behavior Plan? ☐ Yes ☐ No

Please describe any serious illnesses, accidents, or hospitalizations:

Is your child currently taking medications? ☐ Yes ☐ No
If yes, please list: ____
____

Is your child receiving service(s) from another agency? ☐ Yes ☐ No
If yes, please list: ______________________ ______________
Name of Agency Phone

Please tell us anything else that you think would be helpful in planning for your child's success at school.

______________________ ______________________ ______________________
Signature of Person Making Referral Title Date

- -

For School Use Only

Date Received: ______________ Received by: ______________________ Title: ______________

School 504 team: ☐ Approved ☐ Denied