Section 504 Accommodation Plan*

School Year: ____________

School DBN and Name: ____________

Date of 504 Team Meeting: ____________________

**For students with diabetes who require accommodations, utilize the Section 504 Plan Diabetes Template.*

This Plan will be reviewed as needed and before the end of each school year and, if necessary, amended at the time of the review. Parent/guardian will inform the 504 Coordinator of any changes to the student's disability at any point during the school year that may require review of this Plan.

504 Coordinator will complete this Plan with 504 Team (including parent/guardian) input and based upon relevant documentation (*e.g.*, reports, evaluations or diagnoses provided by the student's parent/ guardian, student's grades, disciplinary referrals, health information, language surveys, parent/guardian information, standardized test scores, and teacher comments).

Student & Family Information	
Student Name	Disability/Diagnosis: *(from Medical Accommodations Request Form)*
OSIS #:	Classroom/Homeroom Teacher:
Parent/Guardian Preferred Spoken Language:	Grade:
Home Address:	Paraprofessional (if applicable):
DOB:	

Emergency Contact Detail	
Contact 1	**Contact 2**
Name:	Name:
Relationship to Student:	Relationship to Student:
Home Phone Number:	Home Phone Number:
Work Phone Number:	Work Phone Number:
Cell Phone Number:	Cell Phone Number:

Emergency Contact Instructions: In the event of emergency, the student's Plan and MAF (if relevant) will remain in effect.

504 Team Information

Name	Role
1.	504 Coordinator
2.	Parent/Guardian
3.	
4.	
5.	
6.	

Services & Accommodations

504 Coordinator enters all authorized Services & Accommodations, specifies the accommodations to be provided *(e.g.: Test Accommodations – smaller setting with no more than 12 students, extended time to 1.5, 5 minute break every 30 minutes)*, and marks any fields not applicable *N/A*.

Accommodation and Description of Accommodation
☐ ACCESSIBLE SITE
☐ AIR CONDITIONING
☐ AMBULATION ASSISTANCE
☐ ASSISTIVE TECHNOLOGY
☐ CLASSROOM ACCOMMODATIONS

Accommodation and Description of Accommodation (Continued)
☐ HEALTH PARAPROFESSIONAL
☐ ELEVATOR PASS
☐ EPI-PEN
☐ RESTRICTED ACTIVITY
☐ SAFETY NET (High School only)
☐ TESTING ACCOMMODATIONS
☐ TRANSPORTATION (*As approved by OPT. Consult with school's Transportation Coordinator*)
☐ OTHER - Please describe:

School Responsibilities

Indicate staff who will provide each accommodation

Accommodation	DOE School Staff Name	DOE Title	Responsibilities (if not specified above)
1.			
2.			
3.			
4.			
5.			

I have received the DOE Notice of Non-Discrimination under Section 504 and Notice of Eligibility. By signing, I consent to the provision of accommodations to my child as written above.

Approved and received:

_______________________________ _______________________

Parent/Guardian Date

Approved and received:

_______________________________ _______________________

School Administrator/504 Coordinator and Title Date

ADMINISTRATIVE USE ONLY	
Supporting Documentation *Has the following documentation been submitted to 504Accomdations@strongschools.nyc?* ☐ 504 Accommodation Request Forms ☐ Notice of Non-Discrimination under Section 504 ☐ Notice of Eligibility ☐ Signed 504 Plan ☐ 504 Meeting Attendance Sheet ☐ Allergy or Seizure Plan (*if applicable*) **Health Director Approval** *(If a funded service is authorized by your Health Director.)*	**Notes on Services Not Approved** *Notes from 504 Coordinator*
ASHR Form ID:	