SECTION 504 ACCOMMODATION PLAN

Student Name_____ Birth Date_____

Disability_____ Grade_____ School_____

Initial Evaluation Date_____ Reevaluation Due_____

Beginning Date of this Plan _____ Annual Review Date_____

Describe how the identified disability substantially limits a major life activity:

_____

_____

Accommodation/Action to Be Taken	Setting/Location

Participation in state and district-wide assessment: □ no accommodations
□ accommodations as stated above

Team Signatures	Position	Date
_____	School 504 Team Chairperson	_____
_____	Parent/Guardian	_____
_____	Teacher	_____

CASE, Student Access/Section 504
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