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