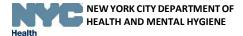
REQUEST FOR SECTION 504 ACCOMMODATIONS 2022-2023

Name of Student	DOB	Student ID# _	
School Name	School ATS/	School ATS/DBNGrade/C	
Name of Requesting Parent/Guardian	Re	elationship to Student	t
Date Submitted to the 504 CoordinatorNa	ame of 504 Coordinator		
Does the student have a current IEP? ☐ Yes ☐ No 5	04 Coordinator Tel. #		
Part 1: Parent/Guardian must complete and submit to th			
Describe the concern below and how it affects the student's performance			
Request accommodations based on the concerns listed above. Proceedings of the concerns listed above.	lease contact your school's 504 Co	ordinator with any ques	tions.
Request for Accommodation(s Guardian Checks all requested:)	New Request For school use only	Renewal Request For school use only
Testing Accommodations		1 or correct use only	Tor correct dec oray
☐ Test schedule/administration time (e.g., extended time, etc.) ☐ Test setting/location			
☐ Method of presentation/Directions/Assistive Technology			
☐ Method of test response/content support			
☐ Other (please specify)			
Classroom / Curriculum Accommodations			
☐ Class schedule/use of time			
☐ Class activities setting ☐ Method of presentation/Directions/Assistive Technology			
☐ Method of class activities response/Content Support			
☐ Other (please specify)			
Academic Supports and Other Services ☐ Paraprofessional			
☐ Nursing Services			
☐ Transportation (if for a temporary medical condition or short- or lo			
Medical Exception Request forms to the Office of Pupil Transportation	on)		
☐ Safety Net (high school only) ☐ Other (please specify)			
When a student requires medication during the school day and is unable to self-	administer, medication is generally administs	_	
Form must be submitted to the school nurse. Requests for 1:1 nursing, paraprofe	essional support, and transportation will be re	eviewed on a case-by-case ba	sis by an Office of School
Health (OSH) Practitioner to confirm that services are medically needed. Additional Education (DOE) will review Assistive Technology requests and may facilitate an			ew York City Department of
Part 2: PARENT CONSENT – Parent/Guardian must complete			
Your child may qualify for accommodations under Section 504 of Th	ne Rehabilitation Act of 1973. Your s	chool's 504 team will me	
records, classwork, classroom observations, testing, and health care p			
will create a 504 Plan with your help and consent. 504 Plans must be		-	
By signing this form: 1) I am giving consent to the 504 team to review I have provided full and complete information to the best of my ability. On the form for their review and decisions. 4) I understand that the OS medical condition, medication or treatment. OSH may obtain this info health services.	3) I understand that the OSH and the I SH and the DOE may obtain any other	DOE are relying on the according information they think is	curacy of the information needed about my child's
☐ Completed HIPAA form attached (REQUIRED FOR REVIEW	. PARENTS MUST COMPLETE TH	E BACK OF THIS FORM	1).
Name of Parent/Guardian		ımber	•
Signature of Parent/Guardian	Baytime i none int		



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Patient Identification Number	
Patient Address			

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- 1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV/AIDS* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7, I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.
- 2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- 3. I have the right to revoke this authorization at any time by writing to the health care providers I have authorized to release my information. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- 4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- 5. Information disclosed under this authorization may be redisclosed by DOHMH or DOE (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
- 6. I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMATION WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION.

CITT DEPARTMENT OF HEALTH AND MENTAL HIGIENE AND THE NEV	V TORK CITT DEPARTIMENT OF EDUCATION.			
radiology studies, films, referrals, consults, billing records, in other health care providers.	stories, office notes (except psychotherapy notes), test results, surance records, and records sent to my health care providers by			
☐ If this box is checked, release and discuss only health information specified here:				
Include: (Indicate by Initialing) Alcohol/Drug Treatment Information. Specify records to Mental Health Information HIV/AIDS-Related Information	be released and releasing organization:			
8. REASON FOR RELEASE OF INFORMATION: THIS INFORMATION IS RELEASED AT REQUEST OF THE PATIENT OR REPRESENTATIVE, UNLESS OTHERWISE SPECIFIED HERE:	9. THIS AUTHORIZATION EXPIRES ON THE DATE THAT PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS OTHERWISE SPECIFIED HERE**:			
10. IF NOT THE PATIENT, NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)	11. THE PERSON SIGNING THIS FORM IS AUTHORIZED BY LAW TO SIGN ON BEHALF OF THE PATIENT AS THE PARENT OR LEGAL GUARDIAN OF THE PATIENT, OR AS SPECIFIED HERE:			
All items on this form have been completed, my questions about this f	form have been answered and I have been provided a copy of the form.			
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW	DATE			

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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^{**}If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law.