

ELIGIBILITY FOR 504 ASSISTANCE

(check applicable areas):

- | | |
|--------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> caring for one's self | <input type="checkbox"/> speaking |
| <input type="checkbox"/> performing manual tasks | <input type="checkbox"/> breathing |
| <input type="checkbox"/> walking | <input type="checkbox"/> learning |
| <input type="checkbox"/> seeing | <input type="checkbox"/> working |
| <input type="checkbox"/> hearing | <input type="checkbox"/> other: _____ |

_____ disability

_____ type of documentation

SERVICES REQUIRED

- Regular Class x _____
- School Nurse _____
- Aide _____
- Guidance Counselor _____
- _____
- _____
- _____
- _____

Describe areas of need/action to be taken	Team Members	Position	Date