

Section 504 Suspected Disability Referral

Northridge Local Schools

CHILD'S NAME: _____ ID NUMBER: _____ DATE OF BIRTH: _____

CHILD'S INFORMATION

CHILD'S NAME: _____ ID NUMBER: _____ DATE OF BIRTH: _____

Please complete this form if you suspect that this student may have a physical or mental impairment that substantially limits one or more major life activities.

NATURE OF CONCERN (attach additional documentation if necessary)

1. Check the suspected physical or mental impairment.

- Allergy _____ Asthma Attention deficit disorder/ADHD Brain injury
- Cancer Cerebral Palsy Developmental aphasia Diabetes Dyslexia Emotional illness
- Epilepsy Hearing impairment Heart disease Minimal brain dysfunction Multiple sclerosis
- Muscular dystrophy Orthopedic impairment Recovering chemically dependent Seizures
- Speech impairment Visual impairment Other: _____

State any evaluative/data source supporting the suspected impairment.

2. Identify any major life activity(ies) and/or major bodily function(s) that are limited.

activities:

- Bending
- Breathing
- Caring for ones self
- Communicating
- Concentrating
- Eating
- Hearing
- Learning
- Lifting
- Performing manual tasks
- Reading
- Seeing
- Sleeping
- Speaking
- Standing
- Thinking
- Walking
- Working
- Other: _____

bodily functions:

- Bladder
- Bowel
- Brain
- Circulatory/Cardiovascular System
- Digestive system
- Endocrine system
- Immune system
- Neurological system
- Normal cell growth
- Respiratory system
- Reproduction
- Other: _____

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3. Indicate how any major life activity(ies) and/or major bodily function(s) is/are substantially limited.

4. To date, what accommodations/modifications/interventions or special provisions have been made to assist the student?

Signature of Person Making Referral Relationship to Student Date

The signature of the individual receiving this referral documents that a copy of this form and Section 504 Procedural Safeguards have been given or sent to the parent or guardian.

Signature of Person Receiving Referral Title of Person Receiving Referral Date Received