SECTION 504 SUMMARY EVALUATION REPORT

**Personal Information:**

Student Name: DOB

Sex: M ( ) F ( ) Grade: School:

Student Address: City: Zip Code:

Parent Name: Phone: (home) (work)

 (cell)

The team met on (date)

The Notice of Section 504/ADA Procedural information and Rights was presented with explanation by: .

**Conference Type:** Initial Case Review Re-evaluation

Sources of Information Considered by RtI team in determining Eligibility:

 \_\_\_\_\_\_\_Parent Recommendation \_\_\_\_\_\_\_\_Physician Diagnosis

 \_\_\_\_\_\_\_Educational Evaluation/Performance \_\_\_\_\_\_\_\_Major Health Problems

 \_\_\_\_\_\_\_Teacher Observation/Recommendation \_\_\_\_\_\_\_\_Behavioral Evaluation/Performance

 \_\_\_\_\_\_\_Ineligibility for Services under IDEIA \_\_\_\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Summary of data and evaluation information that was presented

**Committee Determinations:**

 1. The student has a physical or mental impairment. \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_No

 \*See attached documentation of medical condition.

 o Asthma o Dyslexia o Muscular Dystrophy

 o Attention Deficit/ o Emergent Allergy o Orthopedic Impairment

 Disorder/ADHD o Emotional Illness o Recovering Chemically

 o Brain Injury o Epilepsy Dependent

 o Cancer o Hearing Impairment o Seizures

 o Cerebral Palsy o Heart Disease o Speech Impairment

 o Developmental o Minimal Brain o Visual Impairment

 Aphasia Dysfunction o Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 o Diabetes o Multiple Sclerosis

List attached sources of documentation:

2. If student has a physical or mental impairment in #1 above, does the impairment result in a substantial limitation of one or more major life activity(ies)? \_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_No

Summarize the impairment for each condition identified in relation to the average student:

3. Identify any major life activities or major bodily functions that are substantially limited.

 a. Check any major life activities that are substantially limited:

 o Bending o Breathing o Caring for one’s self

 o Communicating o Concentrating o Eating

 o Hearing o Learning o Lifting

 o Performing manual tasks o Reading o Seeing

 o Sleeping o Speaking o Standing

 o Thinking o Walking o Working

 o Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 b. Check any major bodily functions that are substantially limited:

 o Bladder o Bowel o Brain

 o Circulatory/ o Digestive System o Endocrine System

 Cardiovascular System o Immune System o Neurological System

 o Normal Cell Growth o Respiratory System o Reproduction

 o Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Determination:**

* The student is eligible under Section 504/ADA as a person with a disability for the following conditions.
* The student is not eligible under Section 504/ADS as a person with a disability.

**Recommendations:**

 A Section 504 Plan is recommended.

 The student does not have a physical or mental impairment that substantially limits a

 major life activity and is not eligible for a Section 504 Plan.

 Other

**Review Date:**

**Signatures:**

|  |  |  |
| --- | --- | --- |
|  | **Agree** | **Disagree** |
| **Parent/Guardian** |  |  |  |
| **Principal** |  |  |  |
| **Teacher** |  |  |  |
| **Nurse** |  |  |  |
| **Counselor** |  |  |  |
| **Psychologist** |  |  |  |
| **Other** |  |  |  |
| **Other** |  |  |  |

**Acknowledgment:**

I received a copy of the Notice of Section 504/ADA Procedural Information and Rights for the current year.

\_\_\_\_\_\_\_\_I agree with the Team’s recommendations as stated above.

\_\_\_\_\_\_\_\_I disagree with the Team’s recommendations as stated above. (Please attach a sheet outlining

those areas of the recommendations with which you disagree.)

**Parent/Guardian Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_