BRISTOLVIRGINIA PUBLIC SCHOOLS Section 504 Plan



ACADEMIC 504 Plan			MEDICAL 504 Plan		
Student:	DOB	School:	Grade:		
Meeting Date:	Eligibility Da	te:	Plan Start Date:		
Student ID:	Testing ID:		Race:		
Description of the impact of	f the student's impair	ment on the iden	tified major life activity(ies) from	<u>ı the</u>	
Section 504 Eligibility:					

<u>Present Level of Performance:</u> Academic Strengths:

Academic Needs:

Behavioral/Functional Skills:

Medical Needs:

- Yes No The student will be at a grade level for which the student is eligible to participate in a state or division-wide assessment?
 Yes No The student is being considered for the Credit Accommodation for a local verified credit (complete required forms).
 Yes No The student's disability requires related services:
 - Nursing OT PT Other

The student requires the following accommodations, modifications, and/or medical actions: (Attach as needed)

Service/Accommodation	Frequency	Setting	Person Responsible

Signatures of Meeting Participants

Name	Title	Date	Agree	Disagree

Signatures of those responsible for awareness and/or implementing a health/medical related 504 plan:

Name	Title	Date

I give consent to implement the 504 Plan I do not give consent the 504 Plan

____ I have received a copy of the Section 504 Procedural Safeguards and the Section 504 Plan.

Parent/Guardian Signature