

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

Date