

Attachments  Yes  No

**§504 ACCOMMODATION PLAN**

<b>Student Name</b> _____	<b>OSIS</b> _____	-	_____	-	_____	<b>DOB</b> _____
<b>School</b> _____	<b>School §504 Coord.</b> _____					
<b>Physical or Mental Impairment(s)</b> _____						
_____						
<b>Team Members:</b> _____						
_____						
						<b>Date of Meeting:</b> _____

1. Specific accommodations to be given to the student (Identify the staff members responsible for monitoring their provision) (If extra pages are necessary, please note below and check above for attachments).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Student Responsibilities\*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Parent/Guardian Responsibilities\*

\_\_\_\_\_

\_\_\_\_\_

**RECOMMENDED START DATE FOR ACCOMMODATIONS:** \_\_\_\_\_

**PARENT/GUARDIAN CONSENT**

I have received notice of my procedural due process rights and understand that I have a right to contest the decisions made by the §504 Assessment Team contained in this §504 Accommodation Plan. I understand that no accommodations will be provided until I return this signed consent to the School §504 Coordinator.

By signing, I agree with the Accommodation Plan as written above and consent to the provision of accommodations to my child as recommended by the §504 Assessment Team.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date