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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_