Plainfield Public Schools

Office of Student Intervention & Family Support Services
1200 Myrtle Ave
Plainfield, NJ 07063
(908) 731-4200 ext. 5242

Elizabeth Filippatos, Executive Director of Student Services **Ayesha Howard, District 504 Coordinator**

Section 504 Referral Application

A student must have a physical or mental impairment that substantially limits one or more major life activities in order to be eligible for a Section 504 Plan. Please see attached overview for detail requirements.

Student Name: _____ ID#: _____

School: _____ Grade: _____

1. State the student's suspected physical, mental, or medical impairment: _____

_____

2. Indicate the major life activity or activities believed to be impacted: (If learning is the impacted major activity, refer the case to the CST & SIFSS).

___ self care ___seeing ___breathing ___walking ___hearing ___speaking
___learning ___performing manual task ___other: _____

3. Aptitude and Achievement Evaluation: Standardize Test: ____ District Test: _____ Retention _____

4. School Attendance: # of tardies_____ # of absences_____ #of suspensions: _____

5. Classroom Performance: Complete assignments ___ yes ___ no: stays on task ___ yes ___ no

6. Classroom and General Behaviors: _____

_____

7. Medical and Health Records: _____

8. Other: _____

_____ _____
Name of Person Making Referral Signature

_____ _____
Title Date

Date Rcvd. by School's 504 representative: _____

Date Rcvd.by District's 504 Coordinator: _____

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PHYSICIAN'S STATEMENT

The Plainfield Public Schools district seeks information from you for the purpose of education planning. Please complete the form, sign, and return Copy to **Parent / or** to:

Office of Student Intervention & Family Support Services,
1200 Myrtle Ave
Plainfield, NJ 07062
Attn: Ayesha Howard, MSW, M.A. Ed.
District's 504 Coordinator

Physician's Name: _____

Address: _____

Physician's ID#: _____ Telephone: _____

Completed by School:

Student Name: _____ ID#: _____

School: _____ Date of Birth: _____

Parent Name: _____ Telephone: _____

Complete by Physician

Nature and extent of physical/health/medical condition (attach medical records): _____

_____

Date of onset: _____ Prognosis: _____

Medication prescribed /Dosage: _____

How does this condition impact the student? **Please provide a detailed description:**

_____ _____

Signature and Title of Physician/Representative Date of Examination

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RELEASE OF INFORMATION CONSENT FORM

Student's Name_____ ID#: _____ DOB: _____

I hereby authorize (insert name of agency) _____ to release the following information to regarding services provided for my child (insert name of child) _____.

Information to be released: _____

_____

The purpose for making this information available is to: _____

_____

I certify that I am the parent or legal guardian of the child named above or that I am a student of majority age and have the authority to sign this release.

_____ _____

Name (Print) Signature

_____

Address City, State Zip Code

_____

Date

Please return this form to: _____

Name of School

_____

Address