



## WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

### 504 PARENT REFERRAL FORM

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Counselor:** \_\_\_\_\_

**Parent(s) Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

1. Describe the nature of the disability and how it affects your child's current academic program.

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2. Describe how the student's disability affects a major life activity (such as hearing, walking, seeing, speaking, breathing, learning or working). You may attach supporting documentation (i.e.- medical diagnosis), but you are not required to do so.

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3. What, if any, specific modifications are you seeking?

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In order to help the Intervention & Referral Services Committee evaluate your request, we ask that you return this form to your child's school counselor. Any additional documentation you can provide, such as a medical diagnosis or evaluation, is encouraged but not required.

**Parent(s) Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_