

Section 504 Plan

_____ **LEA NAME**

Student Full Name_____

Date_____

School_____

Date of Birth_____

Parent(s)/Guardian(s)_____

Grade_____

Address_____

WVEIS #_____

City/State/Zip_____

Telephone_____

Initial Section 504 Plan Section 504 Plan Review Amended on _____

Date the Section 504 Plan will become effective _____ Anticipated date for the next Section 504 Review_____

List the student's qualifying impairment(s):_____

Does this student require testing accommodations for the General Summative Assessment for grades 3-8, SAT School Day or NAEP?

YES NO If yes, complete and attach the Section 504 Assessment Accommodation Form

Does the student also have an English Learner (EL) Plan? YES NO If yes, attach the plan

Does the student have an individualized nursing health plan (IHP)? YES NO If yes, attach the plan.

Does the student require any related services? YES NO If yes, attach the related service page.

Does the student have a Behavior Intervention Plan (BIP)? YES NO If, yes attach the plan.

List the reasonable accommodations necessary for the student based on their impairment(s):

ACCOMMODATION	FREQUENCY	LOCATION(S)	PERSON(S) RESPONSIBLE

SECTION 504 ATTENDANCE

(Signing only indicates that the person participated. It does not imply agreement with the entire document)

Signature

Position

School Section 504 Coordinator/Chairperson

Teacher

Evaluator

School Nurse

Parent/Guardian/Adult Student

Student

The following people attended by phone or through a virtual platform:

Printed/Typed Name

Position
