MSAD 49
SECTION 504 REFERRAL FORM

Student's Name:		DOB:	
School:		Grade:	
Teacher:			
Counselor:			

1a. Person who is making this referral:

1b. Are you the student's parent/guardian? ☐ YES ☐ NO

- If NO, has the parent been informed? ☐ YES ☐ NO

2a. Briefly describe the areas of concern for this student:

2b. Briefly describe any attempts to address these concerns:

3a. Has this student ever been referred or identified for special education or Section 504 services previously?

☐ YES ☐ NO ☐ Do Not Know

3b. If YES, please describe any decisions reached about the student's eligibility or placement, to the extent known:

4. Please list and attach any supporting documentation (including diagnostic, testing, reports, etc.) or other information that may be useful in processing this referral:

5. Suspected Disability:

Person Completing Form	Title	Date

Signature of Building 504 Coordinator	Date Received

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