Wilson Central School District
P.O. Box 648 • 374 Lake Street • Wilson, NY 14172

SECTION 504 REFERRAL FORM

SCHOOL: **DATE:**

STUDENT: **DOB:**

ADDRESS: **GRADE:**

PARENT(S)/GUARDIAN(S): **PHONE:**

1. Please describe the nature of the child's suspected/actual physical or mental impairment (check all that apply).

□ Reading □ Writing □ Math □ Listening Comprehension □ Speaking	□ Attention to Task □ Socializing □ Emotional Regulation □ Caring for Oneself □ Breathing	□ Hearing □ Vision □ Fine Motor Functioning □ Gross Motor Functioning
□ Other (Please describe):		

2. Please describe how this impairment impacts the child's functioning throughout the school day:

3. Please describe any services, accommodations, adaptations, modifications, and/or related aids or services the child has received and indicate if the service is received by district staff or an outside/private provider.

□ Speech Therapy □ Occupational Therapy □ Physical Therapy □ Vision Therapy □ Hearing Therapy Counseling	□ Preschool □ AIS □ Reading Lab □ Math Lab □ Behavior Plan □ Test Accommodations	□ Special Education Services □ Adaptive Equipment: □ Medication: □ Medical Equipment (circle): glasses, hearing aide, leg braces, wheel chair,
□ Other (Please describe):		

4. Please list any additional concerns/pertinent information:

SIGNATURE: _____ **DATE:** _____
PARENT SIGNATURE:_____ **DATE:**_____

Received by 504 Office: Date: Initials: