APPENDIX P

SECTION 504 ACCOMMODATION PLAN

Student's Name _____ Birth Date _____

Disability _____ Grade _____ School _____

Initial Evaluation Date _____ Reevaluation Due _____

Beginning Date of This Plan _____ Annual Review Date _____

Describe how the identified disability substantially limits a major life activity: _____

_____

_____

Accommodation/Action to Be Taken	Setting/Location

Participation in state- and district-wide assessment: ☐ no accommodations
☐ accommodations as stated above

Team Signatures	Position	Date
_____	Section 504 Team Chairperson	_____
_____	Parent/Guardian	_____
_____	Teacher	_____