



Section 504 EEOP Health Care Attachment

Student Name _____ **School** _____

Major Bodily Function (Health/Medical Condition) _____

Evaluation Information (Check blocks that apply; include documents for checked items in student 504 folder)

Physician's report	Nurse	Teacher report	Home and health history
Discharge summaries	Previous plan	Parent information	Other

List symptoms associated with the health/medical condition:

1. _____
2. _____
3. _____
4. _____
5. _____

Accommodation/Procedure
(If needed attach another page)

Responsible Individual
(Nurse, teacher or student)

Check all applicable (Attach additional documentation)

Identify immediate responders

Substitute teacher plan

Protocol training

Emergency contact plan

Special field trip instructions

Other _____

Team Signatures/Titles

Date

Area(s) of Expertise

_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

I participated in the development of this accommodation plan, give consent for its implementation and have a received a copy of the Notice of Parents Rights.

Parent Signature

____/____/____
Date

Please outline and estimate the staffing and/or financial resources you are requesting.

Please send a copy of this completed form to the District 504 Director

District Director _____

____/____/____

Original: 504 Folder

Copy: Parent

Attachment: Notice of Parents Rights