St. Lucie Public Schools

Section 504 Individual Accommodation Plan

Student Name	ID #	Date of Birth	School	Grade	Section 504 Condition

Type of Plan	☐ Initial Plan ☐ Reevaluation Plan ☐ Interim Plan for Transfer Students Originating School/District _____
Duration of Plan	Begin date: End Date: 3 yrs or <6 mos if TI If temporary (TI) or other (OR), describe condition
Medical Information	Name of Physician(s): Phone: Medication #1 Dosage Schedule Person Responsible ☐ Parent (at home) ☐ Health Aide (at school) ☐ Other _____ Medication #2 Dosage Schedule Person Responsible ☐ Parent (at home) ☐ Health Aide (at school) ☐ Other _____ Medication #3 Dosage Schedule Person Responsible ☐ Parent (at home) ☐ Health Aide (at school) ☐ Other _____
HCP	☐Yes ☐ No If yes, date of plan _____ Attach Student Health Care Plan
Accommodations	Physical Arrangement of the Room:
	Behavior:
	Assignment Adaptation:
	Test Taking- State & District Assessments
	Lesson Presentation:
	Organization:
	Medical:
	Vocational/Occupational (14 yrs. And older):
	Special Considerations:

Committee Signatures			
	Section 504 Designee	Evaluation Specialist	Nurse
	Administrator	Teacher	Teacher
	Teacher	Teacher	Teacher
	Other	Other	Other
	Parent/Guardian Signature: I have received a copy of the Parent/Student Rights in identification, evaluation, and placement under Section 504 of the Rehabilitation Act of 1973. Parent/Guardian initials _____ Date ____/____/____		