SECTION 504 ACCOMMODATION PLAN

Student 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
_____	School 504 Team Chairperson	_____
_____	Parent/Guardian	_____
_____	Teacher	_____

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