Bloomington Public School District 87
300 E. Monroe Street Bloomington, IL 61701
Telephone 309.827.6031 | Fax 309.828.2917
www.district87.org

504 Conference Summary Report

Conference Date:

Student Identification Information

Student's Name: _____ **DOB:** _____ **Gender:** _____
Academic 504

Address: _____

Ethnicity: _____

Student Phone: _____ **Home Phone:** _____

Parent/Guardian: _____ **Work Phone:** _____

Address: _____

Other Parent/Guardian: _____ **Other Parent Phone:** _____

Address: _____

SIS Number: _____ **Home School:** _____

Current School Year: _____ **Serving School:** _____

Grade Placement: _____ **Next Home School:** _____

Next School Year: _____ **Next Serving School:** _____

Next Grade Placement: _____ **Serving District:** _____

Annual Review Due Date: _____ **Resident District:** _____

PARTICIPANTS

Signature indicates attendance.

Student	Physical Therapist
Parent/Guardian	Occupational Therapist
Parent/Guardian	School Psychologist
LEA Representative	Nurse
Special Education Teacher	Special Education Administrator/Director/Designee
Speech/Language Pathologist	Bilingual Specialist / Interpreter
Principal	Social Worker
General Education Teacher	Other (specify)

Document the attempts made to arrange a mutually agreeable time to meet.

1.
2.
3.

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504 Conference Summary Report

PARENTS' RIGHTS

Explanation of Parents' Rights was provided to/reviewed with the parent(s):(date) _____

(Parent/Guardian Initial): _____

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Parent/Guardian Consent for Evaluation

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Parent/Guardian: _____

Section 504 of the *Rehabilitation Act of 1973* prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. Students who are covered by 504 are those who

1) have a physical or mental impairment, which substantially limits one or more major life activities and results in a need for reasonable accommodations and/or special education and related services,
2) have a record of such impairment or
3) are regarded as having such impairment.

Step One: Explanation and Purpose of an Evaluation

The District shall ensure that a full and individual evaluation is conducted for each child being considered or reconsidered for 504 services and related services.

The purposes of an evaluation may be to determine:

- Whether the child has, or continues to have, a mental or physical impairment;
- Whether the mental or physical impairment substantially limits a major life activity;
- Whether the child needs, or continues to need, reasonable accommodations and/or special education and related services;
- The present levels of performance and educational needs of the child; and/or
- Whether any additions or modifications to the child's 504 Student Plan are needed.

Step Two: Check the Major Life Activity that May Be Affected

☐ seeing	☐ hearing	☐ breathing	☐ caring for one's self
☐ eating	☐ sleeping	☐ lifting	☐ walking
☐ learning	☐ reading	☐ working	☐ performing manual tasks
☐ standing	☐ bending	☐ thinking	☐ communicating
☐ speaking	☐ concentrating	☐ the operation of a major bodily function	

☐ other(specify): _____

Step Three: Sources of Evaluation Information

☐ medical reports/health information	☐ adaptive behavior scales/behavior scales
☐ teacher/psychologist observation	☐ discipline/attendance records
☐ achievement tests	☐ student progress reports/grades
☐ cognitive assessments	☐ functional behavior assessment
☐ language surveys/assessments	☐ parent input
☐ motor assessments	

☐ other(specify): _____

Step Four: Parental Agreement

I understand my rights as explained to me and contained in the Parents Rights in Brief which I have received and reviewed. In addition, I understand the nature and scope of the evaluation to be completed. Upon completion of my child's evaluation, a conference will be scheduled to discuss the findings and determine my child's eligibility for 504 services and related services.

☐ I consent ☐ I do not consent to an evaluation of my child

_____ _____
Signature of Parent/Guardian Date

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Notice of Conference

To: _____ **Date:** _____

Re: (Student Name): _____

Date of Conference: _____ **Time:** _____

Location of Meeting: _____

☐ Parent waived ten day notice. Parent initials _____ Date _____
Comments:

Purpose of Conference:

☐ To consider possible eligibility for and/or provision of services and/or accommodations under Section 504 of the *Rehabilitation Act of 1973*.
☐ To review eligibility for and/or services and/or accommodations being provided under Section 504 of the *Rehabilitation Act of 1973*.
☐ Other:

Conference Participants (Title and Name):

_____ _____

_____ _____

You have the right to bring other individuals, at your discretion, to this conference. Please notify your student's counselor if you are in need of an interpreter or translator.

Enc.: Parent Rights in Brief

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Notice of Conference

PARENTS RIGHTS IN BRIEF

Section 504 of the *Rehabilitation Act of 1973*

It is the policy of the Board of Education to provide a free and appropriate public education to each student with a disability. It is the intent of the district to ensure that students who are eligible for services/accommodations within the definition of Section 504 of the *Rehabilitation Act of 1973* are identified, evaluated, and provided with appropriate educational services/accommodations.

Parents (or, if age 18 or older, students) have the following rights under Section 504

1. Right for your child to take part in and receive benefits from public education programs without discrimination because of his/her disability.
2 Right to have an evaluation that draws on information from a variety of sources.
3. Right to be informed of any proposed actions related to identification, evaluation, placement, or provision of a free appropriate public education of your child.
4. Right to examine all relevant records.
5. Right to receive all information in the parent's/guardian's native language and primary mode of communication.
6. Right to periodic reevaluations and reevaluation before any significant change in placement.
7. Right to a manifestation determination review to determine if your child's misconduct was related to his/her disability before any disciplinary removal that constitutes a significant change in placement.
8. Right to have your child receive appropriate educational services/ accommodations if found eligible under Section 504 of the *Rehabilitation Act*.
9. Right to have your child given an equal opportunity to participate in nonacademic and extra curricular activities offered by the district.
10. Right to file a grievance (under the District's Uniform Grievance Procedure) or request an impartial hearing (under the District's Section 504 Procedural Safeguards) regarding an alleged violation of Section 504. You have the right to forego or terminate the District's grievance and/or hearing procedures and contact the U.S. Department of Education's Office for Civil Rights ("OCR"). Copies of the District's Uniform Grievance Procedure and the District's Section 504 Procedures And Procedural Safeguards are available at
11. Right to be represented by counsel in the impartial hearing process.
12. Right to appeal the Superintendent's grievance decision or the impartial hearing officer's decision.

_____
Building Administrator/Designee

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Notice of Conference

Dear _____

Section 504 of the *Rehabilitation Act* requires that school districts document that parents have been provided and understand the Parent/Student rights in Identification, Evaluation and Placement pursuant to Section 504 of the *Rehabilitation Act*.

The attached Parents' Rights in Brief is designed to provide a brief explanation of the important information regarding the safeguards to which parents/guardians and children are entitled. A complete copy of the District's Section 504 Procedures and Procedural Safeguards is available at

_____

Please sign and date below that you are in receipt of your Parents' Rights in Brief.

_____ _____
Parent/Guardian Signature Date

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SECTION 504 ELIGIBILITY CONFERENCE SUMMARY

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

504 Coordinator: _____

Next Review Date: _____ **Next Reassessment Date:** _____

Purpose of Conference:

- ☐ To consider possible eligibility for and/or provision of services and/or accommodations under Section 504 of the *Rehabilitation Act of 1973.*
- ☐ To review eligibility for and/or services and/or accommodations being provided under Section 504 of the *Rehabilitation Act of 1973.*
- ☐ Other:

I. Sources of Data:

- ☐ medical reports/health information
- ☐ adaptive behavior scales/behavior scales
- ☐ achievement tests
- ☐ cognitive assessments
- ☐ language surveys/assessments
- ☐ motor assessments
- ☐ teacher/psychologist observation
- ☐ discipline/attendance records
- ☐ student progress reports/grades
- ☐ functional behavior assessment
- ☐ parent input
- ☐ other (specify) _____

A. Is there documented evidence of a physical and/or mental impairment?
☐ Yes ☐ No (if no, a 504 plan is not required)

B. Is a major life activity substantially limited by the physical or mental impairment?
☐ Yes ☐ No (if no, a 504 plan is not required)

If yes, please check the major life activity(s) that is/are substantially limited.

- ☐ caring for one's self
- ☐ breathing
- ☐ seeing
- ☐ communicating
- ☐ thinking
- ☐ hearing
- ☐ the operation of a major bodily function
- ☐ speaking
- ☐ eating
- ☐ bending
- ☐ learning
- ☐ performing manual tasks
- ☐ sleeping
- ☐ other (specify): _____
- ☐ lifting
- ☐ reading
- ☐ walking
- ☐ working
- ☐ standing
- ☐ concentrating

II. Summary of other points of discussion/recommendations (if applicable):

Conference Participants:

_____ _____

_____ _____

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Section 504 Plan

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

1. Describe the student's mental and/or physical impairment:

2. Describe how the mental or physical impairment substantially limits a major life activity:

3. Describe the services, accommodations, and/or other supports that are necessary (including their frequency, location, and duration) and who will provide them:

4. State- and District-Wide Assessments: (Specify needed accommodations, if any):

5. Additional Comments:

6. Review Date: _____

7. Triennial Reassessment Date: _____

8. Person responsible for overseeing and monitoring the plan: _____

Participants:

_____ _____

_____ _____

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Conference Notes

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Participants:

_____ _____

_____ _____

NOTES/SUMMARY:

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Parent/Guardian Consent for Initial Provision of Section 504 Aids and Services

Student's Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Dear _____

At a recent conference your child was recommended for the initial provision of Section 504 aids and services and a Section 504 plan was developed. Before a school district may provide the aids and services described in your child's Section 504 plan, your informed written consent is required. Your consent is voluntary and you may revoke your consent at any time. If you revoke consent, it does not negate any action that occurred after the consent was given and before it was revoked.

CHECK ONE:

☐ I give consent

For the initial provision of the aids and services as indicated on my child's Section 504 plan. The proposed aids and services have been fully explained to me and are consistent with the Section 504 plan developed for my child.

I understand that my consent is voluntary. I understand that my consent is not required for continued Section 504 aids and services or for a change in the aids and services. At least annually, I will be given reasonable opportunity for comment on and input into my child's Section 504 plan.

I received a copy of the **Parents' Rights in Brief** which have been fully explained to me by school personnel, including the procedures for requesting an impartial hearing.

I understand that as soon as possible following development of the Section 504 plan, but not more than ten (10) calendar days, aids and services will be provided to my child in accordance with his/her Section 504 plan.

☐ I do not give consent

For aids and services indicated in the Section 504 plan.

I understand that the school district will not be in violation of the requirement to make available a free appropriate public education for my child if I refuse to give consent.

☐ I have received

- ☐ Copy of the Section 504 Eligibility Summary
- ☐ Copy of the Section 504 Plan
- ☐ Other

*I have the authority to enter into this agreement and acknowledge that my electronic signature below is legally binding. I agree that electronic versions of this document shall be given the same weight and deference as a hard copy.

Date: _____ **Parent/Guardian Signature:** _____

If you have any questions concerning this process or require additional information regarding your and your child's rights, please contact

Name: _____ **Title:** _____ **Phone:** _____

*I have the authority to enter into this agreement and acknowledge that my electronic signature below is legally binding. I agree that electronic versions of this document shall be given the same weight and deference as a hard copy.

Sincerely, _____
(Signature)

Name: _____ **Title:** _____

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Section 504 Accommodation Checklist

Student Name: _____ **School Year:** _____

Teacher Name: _____ **Quarter:** _____

Course: _____

Listed below are the classroom accommodations on the 504 plan for the student identified above. Please complete this checklist weekly to document use of the listed accommodations in your classroom. Please provide additional notes when more information is necessary.

Form should be returned to: _____

Key: Y = yes, used this week
O = offered, but not utilized by student
NN = not necessary this week
NA = not applicable in this class

Accommodation:	Specifics:	Week of:									

Signature: _____

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Manifestation Determination for Section 504 Students

A. Identifying information:

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Date of Suspension: _____

B. Conference Participants:

_____ _____

_____ _____

C. Team review and determination:

1. What is the misconduct for which disciplinary action has been taken or is being considered?
   Comments:

2. The team has considered and reviewed the following relevant student information in terms of the misconduct subject to disciplinary action:

   Evaluation, diagnostic results or other relevant information, including student's most recent Section 504 evaluation and plan:
   ☐ Yes ☐ No

   Is there a behavior intervention plan as part of the student's 504 plan? ☐ Yes ☐ No

   (If NO, the building team will initiate a Functional Behavioral Assessment and when complete, will convene a meeting on _____ to develop a Behavior Intervention Plan to address the behavior.)

   Observation of the student: ☐ Yes ☐ No

   Comments

3. In determining if the misconduct was a manifestation of his/her disability, the Section 504 team must determine the following:
   (a) If the misconduct in question was caused by, or had a direct and substantial relationship to, the child's disability; or
   (b) If the misconduct in question was the direct result of the District's failure to implement the Section 504 Plan.

4. If the team determines the misconduct was not a manifestation of the child's disability, then the District's regular disciplinary procedures will apply

5. If the team determines that the misconduct was a manifestation of the child's disability
   (a) The team must conduct a Functional Behavioral Assessment and implement a behavior intervention plan (BIP) if this has not already been done prior to the current misconduct;
   (b) If a BIP has already been developed, review and modify it, as necessary, to address the misconduct in question; and
   (c) The team must review the student's current 504 plan and educational placement to determine if it remains appropriate. If the team believes that a significant change in placement may be necessary, the team must initiate a reevaluation of the student.

   Notes:

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Functional Behavioral Assessment

Complete when gathering information about a student's behavior to determine the need for a Behavioral Intervention Plan. If used in developing a Behavioral Intervention Plan, the Functional Behavioral Assessment must be reviewed at a 504 meeting and should be attached to the 504 plan.

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Target Behavior: _____

The Functional Behavioral Assessment must include data collected through direct observation of the target behavior. Attach documentation of data collection.

Participant/Title:

_____ _____

_____ _____

STUDENT STRENGTHS - Include a description of behavioral strengths (e.g., ignores inappropriate behaviors of peers, positive interactions with staff, accepts responsibility, etc.).

OPERATIONAL DEFINITION OF TARGET BEHAVIOR - Include a description of the frequency, duration and intensity of the behavior.

SETTING - Include a description of the setting in which the behavior occurs (e.g., physical setting, time of day, persons involved).

ANTECEDENTS - Include a description of the relevant events that preceded the target behavior.

CONSEQUENCES - Include a description of the result of the target behavior(e.g. removed from the classroom and did not complete assignment. What is the payoff for the student?).

ENVIRONMENTAL VARIABLES - Include a description of any environmental variables that may affect the behavior (e.g., medication, weather, sleep, diet, social factors).

HYPOTHESIS OF BEHAVIORAL FUNCTION - Include a hypothesis of the relationship between the behavior and the environment in which it occurs.

Is this behavior a ☐ Skill Deficit or a ☐ Performance Deficit

Skill Deficit: The student does not know how to perform the desired behavior.

Performance Deficit The student knows how to perform the desired behavior, but does not consistently do so.

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Behavior Intervention Plan

A functional assessment of behavior must be completed and attached prior to developing a Behavior Intervention Plan.

Complete when the Section 504 team has determined a Behavior Intervention Plan is needed.

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Target Behavior(s):	Intervention(s) to be Implemented:	Procedure/schedule for evaluating effectiveness and person responsible:

Date of plan review: _____

Method of home/school communication: _____

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Medical Services Plan

Student Name: _____ **Grade:** _____ **DATE:** _____ **DOB:** _____

Parent/Guardian: _____ **Phone:** _____

Address: _____

Home School: _____

Serving School: _____

Teacher: _____

MEDICAL CONDITION (Example: Diabetes, Feeding Tube, etc):

ALLERGENS (Example: Food Allergies, Latex Gloves, etc):

Please check the following if appropriate:

- ☐ Diabetes
- ☐ Asthma
- ☐ Allergies
- ☐ Seizure Disorder

MEDICATION

Name of Medication: _____

Who Administers: _____

Time Administered: _____ **Dates (if appropriate):** _____

How to Administer:

Reason for Medicine:

Notes:

PROCEDURES

MEDICAL SERVICE PLAN (Include restrictions of movement, feeding, and other activities):

Provider: _____ **Minutes Per Week:** _____

MEDICAL EQUIPMENT USE AND CARE PLAN:

Contact Person For Equipment Maintenance: _____

EMERGENCY EVACUATION PLAN:

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Medical Services Plan

Training Provided On (Date): _____ **Training Provided By:** _____

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Section 504 Goal

Student Name: _____ **Grade:** _____ **Date:** _____ **DOB:** _____

Goal Type: _____

Present Level of Academic Achievement and Functional Performance related to the Goal:

Goal Statement:

Implementor(s):

Progress:

Date: _____ **Evaluated By:** _____

Description: