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	Title/Position	Date
	Section 504 Team Chairperson	
	Parent/Guardian	
	Teacher	