Lawrence Township Public Schools

Lawrenceville, New Jersey 08648

504 Parent Referral Form

Student's Name:_____ Date of Birth: _____

School:_____ Grade: _____ Counselor: _____

Parent(s) Name: _____ Phone Number: _____

Address: _____

I. Describe the nature of the handicap and how your child's current academic program discriminates against them.

_____

_____

_____

II. Describe how the student's handicap affects a major life activity (such as walking, seeing, speaking, breathing, learning or working). Please attach any supporting documentation.

_____

_____

_____

III. What, if any, specific accommodation/modification are you seeking:

_____

_____

_____

In order to assist our committee in properly evaluating your request, we ask that you return this form with a professional evaluation to your child's school counselor.

1. Professional's Name: _____ Phone: _____

   or

2. Doctor's Name:_____ Phone: _____

Under Section 504 regulations, the District is required to evaluate a student only when it has reason to believe that the child needs special education or related services. If the District does not have such a belief, the District is not required to evaluate the student.

Parent(s) Signature: _____ Date: _____