WEBER SCHOOL DISTRICT
504 Accommodation Request

STUDENT_____ SCHOOL_____
Last First Initial

Grade _____ Male_____ Female_____ Student No._____ Date of Birth_____

ADDRESS_____ Home Phone_____
Number and Street

_____
City State Zip

PARENT/GUARDIAN_____ Work Phone_____

Cell Phone _____

STATEMENT OF HEALTH CARE PROFESSIONAL (OPTIONAL)

If provided, this info will be reviewed and considered by the 504 eligibility team.

If including health information, the statement is to be completed by the licensed physician, licensed psychologist, licensed social worker, or licensed health care provider overseeing treatment and verifying the condition requiring the need of 504 accommodations.

DIAGNOSTIC STATEMENT:_____
_____

SYMPTONS:_____
_____Date of onset: _____
Is this a temporary condition ___ or lifelong ___?
Does this condition affect the student's ability to attend school? ___ Explain if necessary _____
_____
_____
How does this affect the student's ability to learn? _____
_____
_____
Are there any 504 accommodations you would suggest for the student?_____
_____
_____
_____

ADDRESS OF HEALTH CARE PROFESSIONAL:_____

PRINTED NAME OF HEALTH CARE PROFESSIONAL:_____

SIGNATURE OF HEALTH CARE PROFESSIONAL:_____DATE:_____

I authorize the physician or other licensed health care provider to release appropriate information the school.

_____ _____
Parent/Guardian Signature Date