504 Student Eligibility

Raleigh County Schools

Student: _____ WVEIS#: _____ Date of Birth: _____

Referred By: _____ School: _____Grade: _____

Case Manager/Teacher: _____ Parent/Guardian Name: _____

Address: _____ Home #: _____Cell #:_____

Data received and reviewed for eligibility consideration (attach all supporting documentation to this form):_____

_____

Must Check One

___**Yes** ___**No** Has a physical or mental impairment

OR

Has a record of such an impairment

Explain: _____

OR

Is regarded as having such as impairment

Explain: _____

Indicate information/data provided to document impairment:_____

Must Check one

Impairment exists in any of the following**:**

___**Yes** ___**No** physiological disorder or condition

OR

___**Yes** ___**No** cosmetic disfigurement

OR

___**Yes** ___**No** anatomical loss affecting one or more of the following body systems: **(check any/all that apply)**

____ Neurological	____ Musculoskeletal	____ Special Sense Organs
____ Respiratory	____ Speech Organs	____ Cardiovascular
____ Reproductive	____ Digestive	____ Genito-urinary
____ Skin	____ Hemic & Lymphatic	____ Endocrine

Must Check one

___**Yes** ___**No** Disability or impairment substantially limits a major life activity.

Check the major life activity(ies) substantially limited or indicate other and identify:

___ Caring for Oneself	___ Performing Manual Tasks	___ Seeing	____ Hearing
___ Eating	___ Sleeping	___ Walking	____ Standing
___ Lifting	___ Bending	___ Speaking	____ Breathing
___ Learning	___ Reading	___ Concentrating	____ Thinking
___ Communicating	___Wording	___ Other: _____(specify)	

(disregard mitigating measures such as medication and hearing aids. Effects of glasses and contact lenses may be considered?)

How long is impairment expected to affect student? _____ (If less than 6 months, not eligible.)

Condition is: ____ Episodic (plan in effect when condition is active) ____ In remission (reconsider planning if returns)

Is at least one **YES** response in each box above? ___ **YES: Eligible** ___ **NO: Not Eligible**

Committee Signature	**Title**	**Date**

**** Minimum of 3 Professional Staff ****

Does the student require a health care plan? _____ Yes _____ No. If YES, contact a school nurse.

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If eligible, however, the 504 Team suspects the student may also be eligible for special education and related services, forward this form and all documentation to the Special Education Office for an evaluation to consider eligibility under WVBE Policy 2419.

If not eligible, document recommendation for SAT from 504 Team:

Next steps: