C

Rockdale County Public Schools
RCPS

Section 504 Referral Form

Today's Date:			
STUDENT INFORMATION			
Student Name		School:	
Student DOB:		Grade:	

REFERRER INFORMAITON			
Name of Person Referring Student:		Relationship to Student:	

MENTAL OR PHYSICAL IMPAIRMENT

Please note: A medical diagnosis does not automatically qualify a student for Section 504 eligibility. Please attach existing medical documentation if available.

Does the student have a medical condition or diagnosis? ☐ Yes ☐ No

If yes, please list the diagnosis:

Diagnosed by:

Date diagnosed:

Is the student taking any medication(s)? ☐ Yes ☐ No

Please list the reason(s) the concern/impairment impacts the student's access to education:

MAJOR LIFE ACTIVITY

(please check all life activities that may be impacted by the condition/impairment)

☐	Caring for one's self	☐	Learning	☐	Eating
☐	Hearing	☐	Thinking	☐	Speaking
☐	Walking	☐	Concentrating	☐	Sleeping
☐	Bending	☐	Reading	☐	Communicating
☐	Standing	☐	Seeing	☐	Other:
☐	Lifting	☐	Performing manual tasks		

IMPACT OF IMPAIRMENT

Please check the box next to the level of impact that you believe the condition/impairment has on the student:

☐ 1) Negligible/None	☐ 2) Mild	☐ 3) Moderate (somewhat impactful)	☐ 4)Substantial (high degree, very limiting)

_____ _____

Signature of Referrer Date

School Use Only:

Date Referral Received: