Berkeley PUBLIC SCHOOLS
Berkeley Unified School District

Request for Section 504 Plan Evaluation and Consent

Student ID		Date	
Last Name		First Name	
School		Date of Birth:	
Grade		Primary Language:	First Request? ☐ Yes ☐ No
Parent(s)/Guardian(s) Name (Please Print):			
Home Address:			
Tel #		Tel #	
Email:		Email:	
What is the reason for request?			

What major life activity is substantially limited? *(Check all that apply below.)*

☐ Learning	☐ Seeing	☐ Bending	☐ Brain function
☐ Reading	☐ Hearing	☐ Standing	☐ Reproductive function
☐ Concentrating	☐ Eating	☐ Sitting	☐ Circulatory function
☐ Working	☐ Speaking	☐ Bowel / Bladder function	☐ Neurological function
☐ Thinking	☐ Breathing	☐ Performing manual tasks	☐ Normal cell growth
☐ Communicating	☐ Sleeping	☐ Digestive function	☐ Functions of immune system
☐ Lifting	☐ Walking / Ambulation	☐ Endocrine function	☐ Respiratory function
		☐ Caring for one's self	☐ Other: _________________

Primary Care Doctor:	Tel#:
Check all that apply:	**Contact Name / Tel #**
☐ Prior Special Education Evaluation	
☐ School Records	
☐ Letter from Doctor (M.D. / Ph.D.)	
☐ Professional Evaluation	
☐ Professional Assessment	
☐ Health Records	
☐ Medical Reports / Discharge Plans	
☐ Other	

Who is the individual making the request?	Name (Print)	
	Relationship	

Additional information may be necessary to determine your child's needs and eligibility for accommodations, modifications, or services under Section 504. Evaluation may include, but is not limited to reviewing school records, observations, prior testing, communication with teachers, school staff, and providers, work samples, grades, test scores, other information. School personnel may convene a meeting to review information.

Consent to evaluation for possible Section 504 Plan:	☐ I consent ☐ I do not consent		
Parent/Guardian Signature		Date:	

If specific accommodations, modifications, or services are requested, please indicate on a separate page; Provide description of necessity in order to access education. What is requested? How often? Where? When? Days / Hours?

For Office Use Only: Stamp date received, provide copy to parent / guardian. File securely.		
Received by Staff (Print Name):		Date:

Please return this form to the School Principal (elementary schools) or School Counselor (middle / high school).
Attach supporting documentation to this form.

Privacy Alert: This form and supporting documentation may be shared with employees of BUSD who have involvement in your child's education and professionals contracted with BUSD who have subject matter expertise.

6-15-20