

# Marshall Community Unit School District #C-2

South Elementary – North Elementary – Marshall Junior High – Marshall High School

503 Pine St. Marshall, IL 62441 (217) 826-5912

www.marshalk12.il.us

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## Section 504 Procedures

Revised August 2011



### Section 504 District Coordinators

**Terry Stepp**

South Elementary & North Elementary

**Laura Skeel**

Marshall Junior High & Marshall High School

### 504 Building Contacts

Dana Miller—South Elementary

Tina Grooms—North Elementary

Ruth Lisella—Marshall Junior High

Tina Grooms—Marshall High School

Various documents from school districts, especially Fairbanks North Star Borough School District and Community Unit School District #7, state agencies, organizations, and individuals have been used to create this Section 504 Manual for Marshall Community Unit School District #C-2.

# MARSHALL COMMUNITY UNIT SCHOOL DISTRICT #C-2

## 504 STEP by STEP PROCEDURES

1. A concern is raised about a student with a known medical condition that may substantially limit one or more major life functions.
2. The School Nurse completes **REFERRAL for SECTION 504 EVALUATION** and sends it to the Unit Office to Laura/Terry.
3. Laura/Terry completes the **COSENT for SECTION 504 EVALUATION** and returns it to the school secretary.
  - a. Evaluation components may include:

➤ Record Review	➤ Parent Interview
➤ Medical History Review	➤ OT/PT/SL Screening
➤ Classroom Observation	➤ Disciplinary Review
➤ Teacher Interview	➤ Attendance Record Review
➤ Student Interview	➤ Standardized Test Scores
4. The school secretary sends home **PARENT LETTER**, and **SECTION 504 PARENT GUIDE**, and **CONSENT for SECTION 504 EVALUATION** (with a postage-paid return envelope)
5. Once the **CONESENT for SECTION 504 EVALUATION** form is returned, the responsible parties will complete the evaluation, as indicated on the Consent.
6. Upon completion of the evaluation, the evaluation team will schedule a Section 504 Eligibility Determination Conference. Laura, Terry, and/or Secretary will complete **PARENT/GUARDIAN NOTIFICATION of SECATION 504 CONFERENCE**, and sent to all participants.
7. Eligibility for Section 504 is determined during a Section 504 conference. The **SECTION 504 ELIGIBILITY DETERMINATION** form will be completed; additional evaluation information will be attached.
8. If the student is determined to have a physical or mental impairment that significantly impacts one or more major life functions, the Section 504 Committee will develop a **SECTION 504 STUDENT ACCOMMODATION PLAN** and the **SECTION 504 CUMULATIVE FOLDER INSERT** will be added to the student's cumulative folder.
9. The Section 504 Plan will be reviewed at least once each calendar year, but not less than once per school year. The student's eligibility for of a 504 plan should be evaluated at least every three years.

A review is required prior to a significant change of placement, specifically when a student is excluded from the educational program for more than 10 days. A **SECTION 504 MANIFESTATION** must be completed.

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## REFERRAL for SECTION 504 EVALUATION

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Parent(s) Names: \_\_\_\_\_ Phone: \_\_\_\_\_

Is the student suspected of having a physical or mental impairment which substantially limits one or more major life activities? Or, does the student have a record of such impairment? Or, is the student regarded as having such impairment?

Yes  No  If yes, which major life activity is limited? (Check one or more as appropriate)

- |                                          |                                    |                                                      |
|------------------------------------------|------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Caring for self | <input type="checkbox"/> Speaking  | <input type="checkbox"/> Standing                    |
| <input type="checkbox"/> Hearing         | <input type="checkbox"/> Sleeping  | <input type="checkbox"/> Reading                     |
| <input type="checkbox"/> Eating          | <input type="checkbox"/> Bending   | <input type="checkbox"/> Communicating               |
| <input type="checkbox"/> Lifting         | <input type="checkbox"/> Thinking  | <input type="checkbox"/> Major bodily function (i.e. |
| <input type="checkbox"/> Concentrating   | <input type="checkbox"/> Working   | immune system, normal cell                           |
| <input type="checkbox"/> Learning        | <input type="checkbox"/> Seeing    | growth, digestive, bowel, bladder,                   |
| <input type="checkbox"/> Walking         | <input type="checkbox"/> Breathing | neurological, brain, respiratory,                    |
|                                          |                                    | circulatory, endocrine, and                          |
|                                          |                                    | reproductive functions)                              |
- Other: \_\_\_\_\_

2. Describe the nature of the concern. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does student have a current medical diagnosis? Yes  No  If yes, list here: \_\_\_\_\_  
\_\_\_\_\_

4. Describe how the disability/handicap affects a major life activity: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Additional evaluation required? Yes  No  Date \_\_\_\_\_

Signed: \_\_\_\_\_  
person(s) making referral

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Dear \_\_\_\_\_,

The Marshall Community Unit School District #C-2 does not discriminate in its educational programs and activities on the basis of a student's disability. We have reason to suspect that \_\_\_\_\_ may have a physical or mental impairment that substantially limits one or more major life activities. We would like to conduct an evaluation to determine whether your child may be eligible for a Section 504 Accommodation Plan under the Rehabilitation Act of 1973, so that we can assure that your child's individual needs are met as adequately as the needs of other students.

Please provide consent for us to accomplish this evaluation, by indicating your decision and providing your signature on the enclosed "Consent for Section 504 Evaluation," and return it to your child's school in the self-addressed stamped envelope enclosed. Parents and students have specific rights under Section 504 of the Rehabilitation Act of 1973. These rights are summarized in the enclosed "Section 504 Parent Guide."

Once the information has been reviewed, we will be meeting with you to discuss plans to meet your child's needs. We want to include people on the team who know your child, and would especially value your input.

If you have any questions, please contact your child's principal or the Marshall Community Unit School District Section 504 District Coordinators Laura Skeel and Terry Stepp at (217)826-5912.

Sincerely,

\_\_\_\_\_  
(Principal)

826-\_\_\_\_\_  
(Phone Number)

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## CONSENT for SECTION 504 EVALUATION

Date: \_\_\_\_\_

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Dear: \_\_\_\_\_,

(legal name of parent/guardian)

\_\_\_\_\_ was referred for a Section 504 evaluation

(student's name)

on \_\_\_\_\_ by \_\_\_\_\_ for the following reasons:

(date)

(name of person/title)

\_\_\_\_\_ A review of the referral has determined that an evaluation *is not* appropriate at this time. Explain reason: \_\_\_\_\_

\_\_\_\_\_ A review of the referral has determined that an evaluation *is* appropriate at this time.

This evaluation will consist of the following components:

\_\_\_\_\_ Completed by: \_\_\_\_\_

\_\_\_\_\_ Completed by: \_\_\_\_\_

\_\_\_\_\_ Completed by: \_\_\_\_\_

\_\_\_\_\_ Completed by: \_\_\_\_\_

This evaluation will help identify any needed accommodations or adaptations which may meet your child's educational needs. You will be notified upon completion of this evaluation and invited to a conference to discuss evaluation results and recommendations.

### Parental Consent:

I understand my rights as explained to me and contained in the enclosed **Parent's Rights**. In addition, I understand the scope of the evaluation as indicated above.

\_\_\_\_\_ I give consent for a Section 504 Evaluation.

\_\_\_\_\_ I do not give consent for a Section 504 Evaluation.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## PARENT/GUARDIAN NOTIFICATION of SECTION 504 CONFERENCE

Date: \_\_\_\_\_

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Dear: \_\_\_\_\_

(legal name of parent/guardian)

In order to discuss the educational needs of your child, you are invited to a meeting at:

\_\_\_\_\_ (Location and Address)  
scheduled for \_\_\_\_\_ at \_\_\_\_\_  
(Date) (Time)

The purpose of this meeting is to:

\_\_\_\_\_ Review your child's recent Section 504 evaluation results and recommendations.

\_\_\_\_\_ Review and/or develop your child's Section 504 Accommodation Plan.

\_\_\_\_\_ Other (specify) \_\_\_\_\_

The invited individuals and their titles are listed below:

_____	_____
_____	_____
_____	_____
_____	_____

We highly encourage you to participate in this meeting. If you have any questions, or this date and time is not convenient, please notify \_\_\_\_\_ at \_\_\_\_\_.

Sincerely,

\_\_\_\_\_  
(name and title)

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## SECTION 504 ELIGIBILITY DETERMINATION

*(For Section 504 eligibility, a student's physical or mental impairment must substantially limit one or more major life activities.)*

<b>Student Name:</b>	<b>DOB:</b>	<b>Date of 504 Eligibility Meeting:</b>
<b>School:</b>	<b>Grade:</b>	<b>Responsible Staff Member:</b>

### Conference Participants:

_____	_____
_____	_____
_____	_____
_____	_____

➤ **Section 504 Evaluation (check one):**                       **Initial Evaluation**                       **Reevaluation**

➤ **The Section 504 Team has reviewed and considered the following information: (check all that apply)**

<input type="checkbox"/> Psychological/Psycho-Ed Evaluation*	<input type="checkbox"/> Teacher/administrator input	<input type="checkbox"/> Grade Reports
<input type="checkbox"/> Medical Report	<input type="checkbox"/> Parent Input	<input type="checkbox"/> Disciplinary Record
<input type="checkbox"/> School Social Work Assessment	<input type="checkbox"/> Student Work/Anecdotal Records	<input type="checkbox"/> Attendance Record
<input type="checkbox"/> OT/PT/SL Screening/Evaluation	<input type="checkbox"/> Standardized Test Data	<input type="checkbox"/> Academic/Behavioral Interventions
<input type="checkbox"/> School Health Information Health Plan (Attach Plan)	<input type="checkbox"/> Environmental/Cultural/Economic Factors**	

\*Required, if physical or mental impairment impacts learning.      \*\*Conditions resulting from these factors are not necessarily disabilities.

➤ **Specify the student's physical or mental impairment:** \_\_\_\_\_  
*(A physical impairment is any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the body systems. A mental impairment is any mental or psychological disorder. Physical or mental impairments are to be diagnosed by professional persons holding state license or certified through the Department of Education)*

➤ **Is the impairment temporary (with an actual or expected duration):**       **Yes**                       **No**  
 If yes, explain (and indicate actual or expected duration): \_\_\_\_\_

*(A temporary impairment does not constitute a disability for purposes of Section 504 unless its severity is such that it results in a substantial limitation of one or more major life activities for an extended period of time. Note that an individual is not "regarded as" an individual with a disability if the impairment is transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less.)*

➤ **List the major life activity(ies) impacted by the physical or mental impairment:**  
 \_\_\_\_\_

➤ If seeing is listed above, is there a mitigating measure of ordinary eyeglasses or contact lenses?

No       Yes      Describe: \_\_\_\_\_

➤ If yes, does this mitigating measure correct or reduce the effects of the physical impairment?

No       Yes      Describe: \_\_\_\_\_

➤ Identify the referral issues or concerns noted by the parent and student, and/or staff:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

➤ Does the physical or mental impairment substantially limit the major life activity?

*A student is substantially limited when he or she is significantly limited as to the condition, manner, or duration under which he or she can perform a particular major life activity as compared to the condition, manner, and duration under which the average student in the general population can perform that same major life activity.*

Yes       No

➤ Describe the impact, if any, that the physical or mental impairment has on a major life activity

**(without regard to any mitigating measures, i.e. medication):** *(If the impairment is episodic or in remission, describe the impact that the impairment has on a major life activity as if the episode is occurring or the illness is in full force)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

➤ The Section 504 Team has reviewed all available information and concludes the following:

<input type="checkbox"/> The student's disability <b><u>does not substantially limit</u></b> a major life activity. The student <b><u>does not meet</u></b> Section 504 eligibility criteria.  <input type="checkbox"/> Reevaluation complete. The student's disability <b><u>no longer substantially limits</u></b> a major life activity. The student <b><u>meets Section 504 dismissal</u></b> criteria.	<input type="checkbox"/> The student's disability <b><u>substantially limits</u></b> a major life activity. The student <b><u>meets</u></b> Section 504 eligibility criteria.  <input type="checkbox"/> Reevaluation complete. The student's disability <b><u>continues to substantially limit</u></b> a major life activity. The student <b><u>continues to meet</u></b> Section 504 eligibility criteria. <input type="checkbox"/> Continue present services with no changes <input type="checkbox"/> Modify the present program (see attached addendum or new plan)
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➤ If eligibility criteria are met for Section 504, complete Section 504 Plan.



➤ **If eligibility criteria for Section 504 are not met, identify any regular education interventions and strategies that may assist the student:**

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**☞ Parent and student, as appropriate, have been provided with a copy of Section 504 Eligibility Determination and Parent/Student Rights.**

**Parent/Student Signature \_\_\_\_\_ [or] Date copies provided via U.S. Mail \_\_\_\_\_**

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## SECTION 504 STUDENT ACCOMMODATION PLAN

Date: \_\_\_\_\_

Grade: \_\_\_\_\_

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. Describe the basis for the determination of the disability (medical records, documentation, etc):
2. Describe the student's disability and the effects on the major life function(2) in the school setting:
3. Describe the student's current level of academic and behavioral performance:
4. List the accommodations necessary for the student's education program, and the person responsible for providing the accommodations:

ACCOMMODATIONS	PERSON RESPONSIBLE

5. List the criteria which will be used to determine the effectiveness of accommodations:
6. Dates service will begin: \_\_\_\_\_
7. Date of next review: \_\_\_\_\_
8. Plan will be monitored by:  
\_\_\_\_\_

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## **SECTION 504 CUMULATIVE FOLDER INSERT**

Date: \_\_\_\_\_

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

A section 504 Folder has been developed for the above named student. This indicates that a Section 504 Referral was made and an evaluation and service plan may have been completed.

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## SECTION 504 MANIFESTATION DETERMINATION

For Section 504 Team meeting when student with a disability faces discipline of more than ten (10) days out of school when constitutes a change of placement.

Date: \_\_\_\_\_

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Description of Misbehavior: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has this student had previous discipline referrals? (If yes, attach discipline records) YES NO

### Review and consider all relevant student information:

Information from Parents: \_\_\_\_\_

\_\_\_\_\_

Information from Evaluations: \_\_\_\_\_

\_\_\_\_\_

Information from Observations: \_\_\_\_\_

\_\_\_\_\_

### Based on the above information, the Section 504 Team has determined that:

\_\_\_\_\_ The conduct was caused by or had a direct and substantial relationship to the student's disability.

\_\_\_\_\_ The conduct was the direct result of the school district's failure to implement the 504 Plan.

If "YES" to either of the above, the behavior must be considered a manifestation of the student's disability.

### Decision:

\_\_\_\_\_ The student's behavior **was not** a manifestation of his/her disability. The relevant disciplinary procedures applicable to students without disabilities may be applied to this student.

\_\_\_\_\_ The student's behavior **was** a manifestation of his/her disability. The team must review the student's 504 Plan and revise the plan to address the behavior.