DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

SECTION 504 REFERRAL FORM

Student Name:	
Today's Date:	
Student's Date of Birth:	
Student's School:	Student's Grade:
Name of Person Making Referral:	
Relationship to Student: ☐ Parent/Guardian ☐ DCPS Staff ☐ Other:	

Does the student have a known disability? ☐ Yes ☐ No

If yes, please explain:

Does the student receive any supports or services outside of school? ☐ Yes ☐ No

If yes, please explain:

Please check areas of concern that affect your student's ability to access the educational program:

☐ Ability to focus on tasks	☐ Fine motor skills	☐ Movement
☐ Ability to follow directions	☐ Frustration / Gives up easily	☐ Organizational skills
☐ Ability to stay on task	☐ Gross motor skills / Coordination / Mobility	☐ Personal responsibility
☐ Articulation / Speech	☐ Hearing ability	☐ Relationships with adults
☐ Attendance	☐ Language skills	☐ Relationships with peers
☐ Communication	☐ Listening skills	☐ Social skills
☐ Disengaged from education	☐ Memory / Retention	☐ Vision
☐ Other:		

Has this student already been evaluated for possible disabilities? ☐ Yes ☐ No

If yes, please explain and provide copies of the evaluations:

Has this student received special education services? ☐ Yes ☐ No

If yes, please explain:

Are you aware of any significant health or emotional traumas this student may have experienced? ☐ Yes ☐ No

If yes, please explain:

Please provide any additional information you have related to this student that would help the 504 Team determine what accommodations or related services may be necessary.

504 Coordinator's Name: _____

Date of Referral: _____

Date Competed: _____