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# Section 504 Referral/Input Form

**Howard County Public School System  
 Ellicott City, MD 21045**

*Section 504 is a civil rights law designed to protect the rights of individuals with disabilities and ensure access to HCPSS programs and activities. A Section 504 referral can be made orally or in writing. This form gathers input that the Section 504 team will consider during the initial evaluation.*

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Student Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Student Grade: \_\_\_\_\_

Name of Person Making Referral: \_\_\_\_\_

Relationship to Student:  Parent/Guardian  HCPSS Staff  Other: \_\_\_\_\_

Has the student previously had any of the following plans:  504  IEP  IFSP  Unknown

**Describe the student's strengths:**

**Are you aware of any physical or mental impairments the student may have?**  Yes  No

*If yes, please explain and attach any reports, diagnosis, or documentation, etc. you wish the 504 team to consider.*

**Please check areas of concern that impact this student's ability to access HCPSS programs and activities:**

<input type="checkbox"/> Ability to focus on tasks	<input type="checkbox"/> Hearing	<input type="checkbox"/> Personal responsibility
<input type="checkbox"/> Ability to follow directions	<input type="checkbox"/> Health related: _____	<input type="checkbox"/> Relationships with peers
<input type="checkbox"/> Ability to stay on task		<input type="checkbox"/> Relationships with adults
<input type="checkbox"/> Articulation / Speech _____		<input type="checkbox"/> Social skills
<input type="checkbox"/> Attendance _____		<input type="checkbox"/> Vision
<input type="checkbox"/> Communication _____		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Emotional _____		
<input type="checkbox"/> Fine motor skills	<input type="checkbox"/> Language skills _____	
<input type="checkbox"/> Frustration / Gives up easily	<input type="checkbox"/> Listening skills _____	
<input type="checkbox"/> Gross motor skills /	<input type="checkbox"/> Memory / Retention _____	
Coordination / Mobility	<input type="checkbox"/> Organizational skills _____	

**Please describe the concerns you selected above and share the reason for the referral to the 504 team.**

**Does this student receive additional support(s) or services in or outside of school?**

Yes    No

*If yes, please explain:*

**Please provide any additional information you have related to the student that would help the Section 504 team determine eligibility under Section 504.**

**Please submit this form to an administrator or a student services staff at the student's school. Once a Section 504 referral has been received, the school team will schedule a Section 504 meeting generally within 30 days. Parents/Guardians will be invited to attend.**