



HAVASUPAI ELEMENTARY SCHOOL SECTION 504 REFERRAL FORM

Student Name and NASIS Number ID:	
Today's Date:	
Student's Date of Birth:	
Student's School:	
Name of Person Making Referral:	Student's Grade:
Relationship to Student: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Havasupai Staff <input type="checkbox"/> Other:	

Does the student have a known disability? If yes, please explain: Yes No

Does the student receive any supports or services outside of school? If yes, please explain: Yes No

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

<input type="checkbox"/> Ability to focus on tasks	<input type="checkbox"/> Fine motor skills	<input type="checkbox"/> Movement
<input type="checkbox"/> Ability to follow directions	<input type="checkbox"/> Frustration / Gives up easily	<input type="checkbox"/> Organizational skills
<input type="checkbox"/> Ability to stay on task	<input type="checkbox"/> Gross motor skills / Coordination / Mobility	<input type="checkbox"/> Personal responsibility
<input type="checkbox"/> Articulation / Speech	<input type="checkbox"/> Hearing ability	<input type="checkbox"/> Relationships with adults
<input type="checkbox"/> Attendance	<input type="checkbox"/> Language skills	<input type="checkbox"/> Relationships with peers
<input type="checkbox"/> Communication	<input type="checkbox"/> Listening skills	<input type="checkbox"/> Social skills
<input type="checkbox"/> Disengaged from education	<input type="checkbox"/> Memory / Retention	<input type="checkbox"/> Vision
<input type="checkbox"/> Other:	<input type="checkbox"/> Drug or Substance Abuse	<input type="checkbox"/> Physical or Health Condition

Has this student already been evaluated for possible disabilities? If yes, please explain and provide copies of the evaluations: Yes No

Has this student received special education services? If yes, please explain: Yes No

Are you aware of any significant health or emotional traumas this student may have experienced? If yes, please explain: Yes No

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 Completed: _____