Section 504/ADA Plan Request
Parent Input Form

Current Teacher:

Name of Student:

Birthdate:

Record of current year's attendance:

Reason for 504 Plan Request:

Check the Major Life Activity Impacted:

_____seeing, _____hearing, _____walking, _____breathing, _____learning, _____manual tasks, _____reading, _____thinking, _____concentrating, _____communicating, _____eating, _____sleeping, _____bowel functions, _____bladder functions, _____digestive functions, or specify alternative of equivalent scope and importance:

Please provide a copy of any documentation from your physician and/or therapist regarding your child's medical diagnosis. Also make note of any relevant medical history that may be related to your concerns.

Academic Concerns:

Behavior/Social Emotional Concerns:

Any Additional Information Pertinent to your Request:

Optional:
Please identify any medications your child is currently taking.

West Amwell Township Elementary School

1417 Route 179 ★ Lambertville, New Jersey 08530-3413
Dr. Michael G. Kozak, Superintendent
Mrs. Deborah Sarmir, Principal
Phone (609) 397-0819 Fax (609) 397-4350
www.westamwellschool.org

Consent to Share Information

The West Amwell Township Elementary School has my permission to secure from or submit to:

_____
(name of organization, doctor, therapist, etc.)
verbal and written information necessary to the understanding of my child,

_____

Contact Information of organization, doctor, therapist, counselor, etc.:

Name: _____

Phone: _____

Fax: _____ Email: _____

Address: _____

_____

_____

Signature of Parent/Guardian: Date:

_____ _____

PLEASE NOTE: This release is in effect for one year from the above date. Consent is voluntary and may be revoked at any time through written request.