**AVON COMMUNITY SCHOOL CORPORATION**

**SECTION 504 CONFERENCE REPORT**

1. **Personal Information:**

Student’s Name: Click here to enter text.

Date of Birth: Click here to enter text.

Sex: Click here to enter text.

Grade: 4

Attending School: Click here to enter text.

Teacher/Counselor: Click here to enter text.

Parent Name: Click here to enter text.

Address: Click here to enter text.

City/State/Zip: Click here to enter text.

Phone: Home: Click here to enter text.

 Work: Click here to enter text.

 Cell: Click here to enter text.

[ ]  **Initial Conference** [x]  **Annual** [ ]  **Manifest Determination/Causal Relationship**

 **Date of Conference:** **Click here to enter text.**

1. **Conference Deliberations** (***Choose at least one.)***
2. Is there a physical or mental impairment? [x] ***Yes*** [ ] ***No***

 Medical Diagnosis: Celiac Disease and Mild Congenital Thrombocytopenia (platelet function defect)

1. Is there a record of such an impairment? [x] ***Yes*** [ ] ***No***
2. Is the student regarded as having an impairment? [x] ***Yes*** [ ] ***No***

 If ***“yes”*** to any of the above questions, specify the **major life activity(s)** impacted:

 Eating

 Does the Committee have sufficient data to consider the determination of disability?

 [x] ***Yes*** [ ] ***No***

1. **Recommendations:**

On the basis of the data presented, the following decision was made:

 [x]  Student qualifies for Section 504 services (refer to "Alternative Learning Plan")

 [ ]  Student does not exhibit substantial limitations to a major life activity.

**Alternative Learning Plan**

|  |  |  |
| --- | --- | --- |
| Limiting Life Activity\* | Accommodation | Implementer |
| Eating  | XXX’s food will not touch any other food to avoid cross-contamination. | Cafeteria Manager |
| Eating | Provide gluten free lunch items from approved list | Director of Food Services and Cafeteria Manager |
| Eating  | Parent will contact the school in advance if XXX is eating school lunch. | Parents |
| Learning | Gluten free materials will be made available for projects in classroom and art | Teachers, school nurse |
| Learning  | If the class has a pizza party, the cafeteria will be notified ahead of time so that a gf pizza will be available. | Teachers |
| Learning | May require extra bathroom time if he is having stomach issues. | Teachers |

**\*** **Limiting Life Activities: Learning, Eating, Sleeping, Thinking, Caring for One’s Self, Breathing, Communicating,**

 **Walking, Interacting with Others, Reading, Everyday Mobility**

* Will student receive standardized testing accommodations? [ ] Yes [x] No

Must be utilizing classroom testing accommodations

to receive same accommodations on standardized assessments.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Accommodations** |  |  |  |  |  |
| Click here to enter text. | [ ] L.A**.** | [ ] Math | [ ] Science | [ ] S.S. | [ ] All |
| Click here to enter text. | [ ] L.A**.** | [ ] Math | [ ] Science | [ ] S.S. | [ ] All |
| Click here to enter text. | [ ] L.A**.** | [ ] Math | [ ] Science | [ ] S.S. | [ ] All |
| Click here to enter text. | [ ] L.A**.** | [ ] Math | [ ] Science | [ ] S.S. | [ ] All |
| Click here to enter text. | [ ] L.A. | [ ] Math | [ ] Science | [ ] S.S. | [ ] All |
| Click here to enter text. | [ ] L.A. | [ ] Math | [ ] Science | [ ] S.S. | [ ] All |

1. **Conference Notes**:

 XXX eats lunch at school every day. The cafeteria will prepare a tray for XXX each day. Parents will notify the cafeteria if XXX is absent. The cafeteria will provide a monthly menu with substitutions for his meals as needed. The school nurse has been a good consultant for the teacher in determining what might be an issue in class.

1. **Conference Participation:**

**Parents/Guardians:**

[ ] a. I/we have been informed verbally and in writing of my/our rights and options

 under Section 504.

[ ] b. I/we agree with the 504 Alternative Learning Plan recommended and give

 permission for the plan to be implemented.

[ ] c. I/we disagree with the Alternative Learning Plan recommended and do not

 give permission for the plan to be implemented.

[ ] d. I/we agree with the decision that my/our child is not 504 eligible and that

 his/her educational services will continue in the general education program.

[ ] e. I/we agree that my/our child is no longer 504 eligible and that his/her

 Alternative Learning Plan will be terminated.

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 ***Parent/Guardian Signature*** ***Date***

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504 Coordinator/Designee School Counselor

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Building Administrator School Nurse

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General Education Teacher General Education Teacher

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Student Other

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Other Other

***Any party to this referral may submit a written opinion***

***within 10 days of the conference to be attached to this report.***