



530 Perryville St • Harrodsburg, KY 40330
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SECTION 504 REFERRAL FORM

Student Name:		School:	
Date of Birth:		Referred by:	
Parent(s):			
Address:			
Phone:		Email:	

I. Specific Reasons for Referral <i>(check all appropriate areas)</i>					
<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	Social/Emotional	<input type="checkbox"/>	Academic
<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Vision	<input type="checkbox"/>	Developmental
<input type="checkbox"/>	Behavioral	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Speech/Language
<input type="checkbox"/>	Other, please explain:				
Summarize the nature of all concerns noted above when considering school-related life functioning:					

II. Has the student been previously referred to or served under IDEA/504?	
<input type="checkbox"/> Yes	Date or Grade if known:
<input type="checkbox"/> No	

III. Health, Physical, or Mental Impairment

Diagnosis/Diagnoses		Allergies	Medications
Has documentation from a licensed or otherwise qualified medical, health, or clinical practitioner been obtained to verify the information above?			
	Yes	Date of documentation: Name of practitioner:	

IV. Academic Characteristics

Current Grade:		Grade Level Performance:	
Retained?		If yes, when?	
Rtl services? Grade and area or concern:			
Attendance Record:			
	<i>See attached attendance log</i>		
Grades:			
	<i>See attached report card</i>		
Testing Data:			
	<i>See attached testing Scores</i>		
Behavioral Concerns:			
	<i>See attached behavior log</i>		

V. Additional concerns for discussion at Section 504 referral meeting

Date referral completed: _____

Signature of person completing referral: _____

(Note – all information must be completed in order proceed)

Date referral received by 504 Chairperson: _____