

COLQUITT COUNTY SCHOOLS

Section 504
INDIVIDUAL ACCOMMODATION PLAN (IAP)

Plan Date: _____ **Projected Review Date:** _____

Student's Name: _____ DOB: _____ Age: _____

School: _____ Grade: _____

Parent/Guardian: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

TEAM Members Present: (print name and give signature)

_____	_____
_____	_____
_____	_____
_____	_____

Describe the student's physical or mental impairment that "substantially limits" one or more major life activity:

Describe the educational limitations experienced by the student as a result of this disability:

Describe the medical limitations experienced by the students as a result of this disability:

List any other limitations which may affect the student's activities while at school:

List the accommodations which are necessary for this student to participate in the education program at this school:

1. _____
2. _____
3. _____
4. _____
5. _____

List any anticipated discipline problems which may result from the disability:

Describe positive behavioral interventions which will be used to address this behavior:

List consequences which may be used when this behavior occurs:

1. _____
2. _____
3. _____
4. _____
5. _____

I was invited to participate in developing this plan for my child. I have reviewed this plan and have received a copy of the Notice of Section 504 Parent Rights. I understand my rights as outlined on the Notice.

_____ Date: _____
Parent Signature

*To be completed if the parent/guardian **did not attend** the meeting:*
_____ #times contacted _____ copy 504 plan sent _____ Notice Parent Rights sent _____ date sent