OCEAN CITY BOARD OF EDUCATION

Section 504 Plan Request

RETURN ALL FORMS AND SUPPORTING DOCUMENTS TO:
OCEAN CITY BOARD OF EDUCATION **Office of Student Services** **Attn: Annemarie Wagner-Fehn** **1801 Bay Avenue** **Ocean City, NJ 08226**

OCEAN CITY BOARD OF EDUCATION

Section 504 Accommodation Plan Request / Referral

_____ _____ **Print**

Student's Name (last, first, middle) **Student's ID Number**

_____

Referring Individual's Name (last, first, middle) **Relationship to Student**

_____

Referring Individual's Phone Number **Referring Individual's Email**

Student's School of Attendance: **___Primary School**
___Intermediate School
___High School

Student's current grade level:_____Student's teacher or guidance counselor: _____

1. **Please describe the student's strengths(s):**
   _____
   _____
   _____
2. **Please describe the student's area(s) of need:**
   _____
   _____
   _____
3. **Do you have evidence that the documented mental or physical impairment impacts the students ability to equally access their education :** YES/NO (if yes, please attach documentation)
4. **Please indicate the area(s) the referring individual believes the documented mental or physical impairment substantially affects the students overall performance in school:**

Seeing	Breathing	Hearing	Eating
Movement	Walking	Learning	Thinking
Standing	Concentration	Speaking	Understanding
Sleeping	Hygiene	Self Care	Other (please specify):

5. **Please provide any additional information that may be pertinent to this Section 504 request:**
   _____
   _____
   _____

- **____I have attached a completed Physician's Certification form.**
- **____The Physician's Certification is being sent under separate cover.**
- **____The student has not yet seen his/her physician. The appointment is _____/_____/_____**
  mm dd yyyy

Referring Individual's Signature: _____ Date _____

Attach any relevant documentation or additional information which may be pertinent to the accommodation review process.

OCEAN CITY BOARD OF EDUCATION

Authorization for Release of Student Records for Section 504 Accommodation Plan Request

_____ _____

Print Student's Name (last, first, middle) **Student's Social Security Number**

_____

Print Physician/Practitioner Name (last, first, middle)

I, _____, parent/guardian/adult student *(circle one)* hereby authorize the above-listed physician/practitioner/school nurse to exchange any Protected Health Information ("PHI"), including, but not limited to, confidential medical, psychological and/or sociological information, to the Ocean City Board of Education (the "Board") for the purpose of disability accommodation request evaluation. By signing this form, I authorize the release of a copy of this student's PHI, or a summary or narrative of this student's PHI to the Board.

Any information shared will be treated in a professional and confidential manner and will be used for the exclusive purpose of disability accommodation request evaluation. Information received by the Board will be placed in the student's confidential file. The effect of granting this authorization may be that the PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Board, its programs, services, employees, officers, agents and/or assigns are hereby released from any legal responsibility or liability for disclosure of this student's PHI to the extent indicated and authorized.

This authorization is given voluntarily. The Board will not condition the grant of a disability accommodation on the giving of this authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Board. I understand that revocation of this authorization will not affect any action taken by the Board in reliance on this authorization before written notice of revocation was received. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

This authorization expires one year from the date of the below signature.

I have had a full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of this student's PHI, as described in this form.

_____ _____

Parent's / Guardian's / Adult-Student's Signature **Date**

Please send requested information to:

OCEAN CITY SCHOOL DISTRICT BOARD OF EDUCATION
OFFICE OF STUDENT SERVICES

ATTN: Annemarie Wagner-Fehn
1801 Bay Avenue
Ocean City, NJ 08226

OCEAN CITY BOARD OF EDUCATION

Physician Certification for Section 504 Accommodation Plan

_____ _____

Print Patient's Name (last, first, middle) **Examination Date**

_____ _____

Print Physician's Name **New Jersey License Number**

___I certify that the above named patient has a documented disability and may require Section 504 accommodations.

Please Check and Complete ONE of the Following Three Options

___ I examined the above-named patient on _____ and certify that the patient has the following functional limitation(s):

_____

_____

_____

___I examined the above-named patient on _____ and I am unable to make a determination without further examination. The patient is scheduled for a follow-up examination on _____ with _____

___I examined the above-named patient on _____ and I have not found any limitations at this time. This patient may return to regular attendance without restrictions on _____

Physician's Comment(s): _____

_____

_____

Physician's Address: _____ Suite _____
City _____ State _____ Zip Code _____

(_____)_____ _____

Physician's Phone Number **Physician's Medical Specialty**

_____ _____

Physician's Signature **Date**

Attach any relevant documentation or additional information which may be pertinent to the accommodation review process