REQUEST FOR SECTION 504 ACCOMMODATIONS 2018-2019

Name of Student _____ DOB ___/___/___ Student ID# _____

School Name _____ School ATS/DBN: _____ Grade/Class _____

Name of Requesting Parent/Guardian _____ Relationship to Student _____

Date Submitted to the 504 Coordinator ___/___/___ Name of 504 Coordinator _____

504 Coordinator Tel. # _____

Part 1: Parent/Guardian must complete and submit to the school's 504 Coordinator

Describe the concern below and how it affects the student's performance at school:

Request accommodations based on the concerns listed above. Please contact your school's 504 Coordinator with any questions.

Request for Educational Accommodation(s) *Check all requested:*		*For school use only* Approve	Deny
Testing Accommodations	☐ Test schedule/administration time (e.g. extended time, etc.)	☐	☐
	☐ Test setting/location	☐	☐
	☐ Method of presentation/Directions/Assistive Technology	☐	☐
	☐ Method of test response/content support	☐	☐
	☐ Other (please specify)	☐	☐
Classroom / Curriculum Accommodations	☐ Class schedule/use of time	☐	☐
	☐ Class activities setting	☐	☐
	☐ Method of presentation/Directions/Assistive Technology	☐	☐
	☐ Method of class activities response/Content Support	☐	☐
	☐ Other (please specify)	☐	☐
Academic Supports and Services	☐ Health Paraprofessional* ☐ new request ☐ renewal request	☐	☐
	☐ Safety Net *(high school only)*	☐	☐
	☐ Other (please specify) _____	☐	☐
Other Accommodation (please specify)**		☐	☐
		☐	☐
		☐	☐

* Paraprofessional requests must be reviewed by an Office of School Health Practitioner in order to confirm that services are medically needed. Additional forms must be completed; please check with your 504 Coordinator.

**For Transportation Requests, complete a Medical Evaluation Request Form. This form can be found on the DOE website.

Part 2: PARENT CONSENT – Parent/Guardian must complete before submitting to your school's 504 Coordinator

Your child may qualify for accommodations under Section 504 of The Rehabilitation Act of 1973. Your school's 504 team will meet to review your child's records, classwork, classroom observations, testing, and health care practitioner's statement. If your child qualifies for services based on that review, the team will create a 504 plan with your help and consent. The 504 plan may be reviewed at any time of the year, **but 504 plans must be reapproved each school year.**

By signing this form: 1) You are giving consent to the 504 team to review your child's records and decide if your child qualifies for accommodation services. 2) You confirm that you have provided full and complete information to the best of your ability. 3) You understand that the Office of School Health (OSH), and the Department of Education (DOE) are relying on the accuracy of the information on the form for their review and decisions. 4) You understand that OSH and DOE may obtain any other information they think is needed about your child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given your child health services.

☐ **Completed HIPAA form attached. (REQUIRED FOR REVIEW. PARENTS MUST COMPLETE THE BACK OF THIS FORM.**)

Name of Parent/Guardian _____ Daytime Phone Number _____

Signature of Parent/Guardian _____ Date _____

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV/AIDS* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 7. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7, I specifically authorize release of such information to the New York City Department of Health and Mental Hygiene ("DOHMH").
2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, DOHMH is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care providers listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by DOHMH (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMAITON WITH, THE OFFICE OF SCHOOL HEALTH, A JOINT PROGRAM OF THE NEW YORK CITY DEPARTMENT OF EDUCATION AND THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE**.

7. Specific information to be released and discussed:

Entire Medical Record (written and oral) including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records send to my health care providers by other health care providers.

☐ **If this box is checked, release and discuss only my Medical Record from the range of dates starting from (insert date)_____ and ending on (insert date)_____.**

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____Alcohol/Drug Treatment Information

_____Mental Health Information

_____HIV/AIDS-Related Information

8. **REASON FOR RELEASE OF INFORMATION: THIS INFORMATION IS RELEASED AT REQUEST OF THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE:**	9. **THIS AUTHORIZATION EXPIRES ON THE DATE THAT PATIENT IS NO LONGER ENROLLED IN A SCHOOL OR PROGRAM OPERATED BY THE NEW YORK CITY DEPARTMENT OF EDUCATION OR SERVICED BY THE OFFICE OF SCHOOL HEALTH UNLESS OTHERWISE SPECIFIED HERE**:**
10. If not the patient, name of person signing form:	11. **THE PERSON SIGNING THIS FORM IS AUTHORIZED BY LAW TO SIGN ON BEHALF OF THE PATIENT AS THE PARENT OR LEGAL GUARDIAN OF THE PATIENT, OR AS SPECIFIED HERE:**

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

****If an expiration date is specified in item 9 above, the form will expire on that date and a new form must be submitted by the parent or legal guardian of the patient, or other persons authorized by law**.