# Student 504 Accommodation Plan

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Student name:       DOB:

School:       Grade:       ID#:

Parent/Guardian:       Phone:

Building 504 Coordinator:       Date

Plan Type: [ ]  Initial [ ]  Annual Review [ ]  Reevaluation

Briefly describe the impairment (both active state and during use of mitigating circumstances) and its impact on the student’s success.

*The following required accommodations are based on the eligibility for 504 services. MCSD recommends accommodations be in place a minimum of two months in an instructional setting prior to use on district or state assessments.*

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| Accommodations required to meet the physical needs of the student. | Responsible Individual |
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|       |       |

|  |  |
| --- | --- |
| Accommodations required to meet the instructional needs of the student. | Responsible Individual |
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| Accommodations required to meet the behavioral needs of the student. | Responsible Individual |
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III. Team Members

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| **Team Member Signature** | **Title** | **Date** |
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