



## Cajon Valley Union School District Parent Request for Section 504 Evaluation

Student's First Name	Student's Last Name	Grade	Age

Address of Student

Parent/Guardian Name	Phone Number	Email
Parent/Guardian Primary Language	Interpretation needed?	Relationship to Student

Student's need/area of concern <i>(check all that apply)</i>					
Caring for one's self	<input type="checkbox"/>	Walking	<input type="checkbox"/>	Seeing	<input type="checkbox"/>
Eating	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Performing Manual Tasks	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	Working	<input type="checkbox"/>	Sleeping	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	Learning	<input type="checkbox"/>	Standing	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	Bending	<input type="checkbox"/>	Reading	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	Thinking	<input type="checkbox"/>	Other	<input type="checkbox"/>

Additional Comments

Other medical records, information or release of information forms attached:

I/we request the above named student be evaluated for eligibility under Section 504 of the Rehabilitation Act of 1973.			
Signature:		Date:	

**Submit to the school Principal or Assistant Principal and attach any additional documentation.**  
Date Received: