

Jackson Local School District

***504 Accommodation Plan**

(*Supports that are necessary for student to have an opportunity commensurate with nondisabled student of approximately the same age.)

Student's Name: _____ DOB: _____ Age: _____ Grade : _____
 School: _____ Contact/Counselor: _____
 Effective Dates: _____ to _____ Parent(s)/Guardian Name: _____
 *Date of Last Evaluation: _____

Area(s) of Difficulty	Accommodations	Start Date	Person Responsible	Outcome/Results

Participation in state and district-wide assessments: ___ No accommodations needed ___ Accommodations needed as indicated with (*) above

Team Members (Name/Title):

_____	_____
_____	_____
_____	_____

Copies sent to: Parent(s) Cumulative Records Special Programs Teachers Contact Person
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*Updated 11/11