REQUEST FOR SECTION 504 ACCOMMODATIONS 2022-2023

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 _____

Does the student have a current IEP? ☐ Yes ☐ No 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 Accommodation(s) *Guardian Checks all requested:*	**New Request** *For school use only*	**Renewal Request** *For school use only*
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 Other Services		
☐ Paraprofessional	☐	☐
☐ Nursing Services	☐	☐
☐ Transportation (if for a temporary medical condition or short- or long-term limited mobility, submit the Medical Exception Request forms to the Office of Pupil Transportation)	☐	☐
☐ Safety Net (high school only)	☐	☐
☐ Other (please specify) _____	☐	☐

When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse; the Medication Administration Form must be submitted to the school nurse. Requests for 1:1 nursing, paraprofessional support, and transportation will be reviewed on a case-by-case basis by an Office of School Health (OSH) Practitioner to confirm that services are medically needed. Additional forms must be completed; please check with your 504 Coordinator. The New York City Department of Education (DOE) will review Assistive Technology requests and may facilitate an evaluation to determine the student's needs.

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. 504 Plans **must be reviewed before the end of each school year** or more often if necessary.

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

Health

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 Act 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") and the New York City Department of Education ("DOE"), which jointly operate the Office of School Health.
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 I have authorized to release my information. 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 may be redisclosed by DOHMH or DOE (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 INFORMATION WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND THE NEW YORK CITY DEPARTMENT OF EDUCATION.**

7. Specific information to be released and discussed:

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

☐ If this box is checked, release and discuss only health information specified here:_____

(Use this box if you do not want the entire record released or disclosed. Use box 9 below to set how long you want this form to last)

Include: (*Indicate by Initialing*)

_____**Alcohol/Drug Treatment Information.** ***Specify records to be released and releasing organization:*** _____

_____**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 DOE OR SERVICED BY THE OFFICE OF SCHOOL HEALTH, UNLESS OTHERWISE SPECIFIED HERE**:
10. IF NOT THE PATIENT, NAME OF PERSON SIGNING FORM: (PARENT/GUARDIAN MUST COMPLETE)	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.**

MEDICAL ACCOMMODATIONS REQUEST FORM
Office of School Health | School Year 2022-2023

This form should be submitted along with all relevant forms to this request. Please attach additional documentation, if needed

Student Name: _____ *OSIS #:* _____ *Student's Date of Birth:* _____

☐ 504 Request ☐ IEP Request IEP Classification: _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

MEDICAL INTERVENTION

Medical Diagnosis _____ /ICD-10 Code/DSM-V Code(s): _____._____ _____._____ _____._____

If the request is for a diagnosis of allergies/anaphylaxis, diabetes, or seizure disorder, please complete the Medical Accommodations Request Form Addendum.

This condition is: ☐ Acute ☐ Chronic Expected duration of accommodation: _____ weeks

Request for: ☐ nursing services ☐ paraprofessional support ☐ transportation ☐ other (see Other Services)

Requests for nursing or paraprofessional support, will be reviewed on a case-by-case basis to determine whether the student needs 1:1 support or school-based support. When a student requires medication during the school day and is unable to self-administer, medication is generally administered by the school nurse. Trained paraprofessionals may administer epinephrine and glucagon; all other medications, including insulin, must be administered by a nurse. Requests for transportation accommodations will be reviewed on a case-by-case basis. Prior to commencement of services, Medication Administration Forms (MAFs) must be submitted for all medications, procedures, supervision, and monitoring performed during school hours.

Student's current clinical status *(level of control, current management plan, pending evaluations, etc.)*:

Type of Medical Intervention:	Intervention Needed
☐ Administration of Medications Please complete and submit all applicable Medication Administration Forms (MAFs: Allergy & Anaphylaxis, Asthma, Diabetes, General, Seizure). ☐ Emergency Medications (e.g. glucagon, rectal diazepam) Please list all emergency medications, including time frame for administration Will student require daily administration of medication during school hours? ☐ Yes ☐ No Will student require in-school medications 3 or more times per day? ☐ Yes ☐ No List daily medications here, or attach MAFs.	☐ during school ☐ during transport
☐ Procedures and Treatments, Routine and Emergency *(e.g., suctioning, airway management, vagal nerve stimulator) Please complete and submit the Request for Provision of Medically Prescribed Treatment Form (Non-Medication)* *Please list, including timing and frequency of administration during the school day.*	☐ during school ☐ during transport
☐ Equipment Management *(e.g., ventilator, oxygen) Please complete the Request for Provision of Medically Prescribed Treatment Form (Non-Medication)* Please list all equipment that will accompany the student during school and/or transport:	☐ during school ☐ during transport
☐ Other Services *Please complete all appropriate forms (MAFs, Request for Provision of Medically Prescribed Treatment Form, if applicable)* ☐ air conditioning ☐ ambulation assistance ☐ elevator pass ☐ other Please list:	☐ during school ☐ during transport

PROVIDERS, PLEASE SIGN PAGE 2 →

MEDICAL ACCOMMODATIONS REQUEST FORM

STUDENT CONSIDERATIONS

Supervision/Monitoring Required: ☐ none ☐ during school ☐ during transport

Supervision/Monitoring Frequency: ☐ continuous ☐ other

Please describe the additional supervision/monitoring needed, including the tasks/responsibilities:

Is the student considered to be medically unstable (At risk for medical decompensation during school or transport)?

☐ Yes (please describe below) ☐ No

Is the student considered to be behaviorally unstable (poses a danger to themself or to other students)?

☐ Yes (please describe below) ☐ No

Does the student currently utilize the following: ☐ Crutches ☐ Cast ☐ Wheelchair ☐ Other: _____

Please list any other clinical concerns relevant to supporting the student during the school day and/or during transport (Attach additional information if needed)

How does this diagnosis affect educational performance? Does the diagnosis have an impact on learning, participation, or attendance in school? If so, please describe.

CONTACT INFORMATION & ATTESTATION

Phone number - Office: _____ Cell: _____ Email: _____

Best days to be reached:

☐ Mon-Time: _____ ☐ Tue-Time: _____ ☐ Wed-Time: _____ ☐ Thu-Time: _____ ☐ Fri -Time: _____

I attest that I have provided clinical services to this student and that the information above is complete and clinically accurate as of the date provided below.

Provider's Name (print): _____ License #: _____

Provider's Signature: _____ Date of completion: _____

MEDICAL ACCOMMODATIONS REQUEST FORM ADDENDUM 2022-2023

To Completed by the Student's Health Care Practitioner

Student Name: _____ DOB: _____ Student ID#: _____

Allergies/Anaphylaxis

(Note Available School-Specific Allergy Resources listed below)

List allergen(s): _____

Source of allergy documentation: ☐ Skin Testing ☐ Blood Test ☐ Parental Report

History of Anaphylaxis? ◯ Yes ◯ No

If yes, specify system(s) affected: ☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic Medications

Medications: _____

Was an **Allergy/Anaphylaxis** MAF completed? ◯ Yes ◯ No

Does the student have a history of developmental or cognitive delay? ◯ Yes ◯ No

If yes, specify diagnosis/diagnoses: _____

Does the student have prior experience with self-monitoring? ◯ Yes ◯ No

Can the student:

- ☐ Independently self-monitor and self-manage?
- ☐ Recognize symptoms of an allergic reaction?
- ☐ Promptly inform an adult as soon as accidental exposure occurs or symptoms appear, or ask a friend for help?
- ☐ Follow safety measures established by a parent/guardian and/or school team?
- ☐ Understand not to trade or share foods with anyone?
- ☐ Understand not to eat any food item that has not come from or been approved by a parent/guardian?
- ☐ Wash hands before and after eating?
- ☐ Develop a relationship with the school nurse or another trusted adult in the school to assist with the successful management of allergy in the school?
- ☐ Carry an epinephrine auto-injector?

Provider Signature: _____

Diabetes

When was the student diagnosed with diabetes? _____

Was a **Diabetes MAF** completed for this student? ◯ Yes ◯ No

Does the student have any cognitive challenges or physical disabilities that interfere with the student providing self-care for their diabetes? Yes

If yes, please specify: _____

Can the student identify symptoms of hypoglycemia? ◯ Yes ◯ No

Can the student notify an adult when they feel that their blood glucose is not normal? ◯ Yes ◯ No

What is the plan to transition the student to independent functioning? _____

Provider Signature: _____

Seizure Disorder

Type of Seizure: _____

Frequency of Seizures _____

Medication(s), including emergency medications: _____

Was a **Seizure MAF** Completed? ◯ Yes ◯ No

Are the seizures well-controlled by the current medication regimen? ◯ Yes ◯ No

Does the student require routine or prn emergency medication in school? ◯ Yes ◯ No

If yes, has an MAF been completed? ◯ Yes ◯ No

Other associated signs and symptoms, including medication side effects: _____

Number of seizure-related ER visits during the past year: _____

Number of seizure-related hospitalizations/ICU admissions: _____

Frequency of office visits/monitoring: _____ ◯ Weeks ◯ Months

Last Office Visit: _____

Activity Restrictions: _____

Provider Signature: _____

DO NOT WRITE BELOW - SCHOOL USE ONLY

Available School-Specific Allergy Resources

- ☐ Allergy Table(s) in the lunchroom: _____ staff members for supervision
- ☐ Allergy Table(s) in the classroom: _____ staff members for supervision
- ☐ General Staff Training for Epinephrine administration: _____ staff members trained
- ☐ Student-Specific Training for Epinephrine administration: _____ staff members trained
- ☐ Allergy Response Plan received from school nurse
- ☐ Other: _____

Name of Principal or Principal's Designee: _____