[NAME] SCHOOL DISTRICT

**SECTION 504 OF THE REHABILITATION ACT OF 1973**

**SECTION 504 PLAN**

Student Name: DOB: Student I.D.:

Date: Purpose: Initial: Triennial: Addendum:

School of Residence: School of Attendance: Grade:

Parent/Guardian Name: Primary Telephone:

Address: Mom’s Cell phone:

Primary Language: Home - Student - Ethnicity:

Next Review Date: Next Re-evaluation Date:

Disability: *Glanzmann’s Thrombasthenia* Initial Eligibility Date:

Student’s Medications: *Saline Nasal Gel*, *Afrin nasal spray, Bleed Cease, Amicar, Thrombin, NovoSeven injection*

Administered at School  Yes  No

Who Administers Medications: *Trained assistive personnel, trained staff* When: *As needed for bleeding or trouble breathing* Where: *Health Office.*

Section 504 Plan Medical Accommodations Plan attached  Yes  No

**COMMITTEE RECOMMENDATIONS**:

Initial Program Continue in present program

Modify regular program (See attached Service Plan, Part II) Exit program

Refer to Special Education Assessment Team

Other (explain):

The following individuals have participated in the recommendations as noted above in accordance with required procedures of Section 504 of the Rehabilitation Act of 1973.

Parent: Administrator:

School Nurse:*,* Student:

Member/Title: [Name] *, Teacher* Member/Title: [Name] *, Health Clerk*

Member/Title: [Name] *, Counselor* Member/Title: [Name] *, PE Teacher*

I have been informed of and understand my rights under Section 504:  Yes  No

**I Agree with the contents of this 504 Service Plan.**

**I Agree with the contents of this 504 Service Plan, except for:**

**I Do Not Agree** with the recommendations included in the 504 Service Plan.

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Parent Signature: Date:

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Parent Signature: Date:

**[NAME] SCHOOL DISTRICT**

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**SECTION 504 OF THE REHABILITATION ACT OF 1973**

# **SERVICE PLAN**

Student Name: Student ID Number: Date:

The following accommodations and/or services offer the least restrictive environment to meet the student’s needs.

|  |  |  |
| --- | --- | --- |
| **No 1. Accommodation/Service**  **Area of Difficulty:**  **PROVISION OF CARE**   1. Medical orders will be followed as written. 2. Student will be monitored by teacher and appropriately trained staff, while on campus. 3. The teacher will receive training that will include a general overview of her medical disorder and care. Typical health care needs of a student will be discussed as well as how and when to immediately contact either the health clerk, school nurse or another staff trained in her medical management. 4. Parents and the school nurse will work together within the first 2 weeks of school to educate [Name] teachers about her diagnosis, general presentation, and medical needs. 5. It is advised that [Name] wear a Medic-Alert bracelet at all times except in situations where doing so could cause potential injury.   **LOCATION OF SUPPLIES AND EQUIPMENT**   1. Medications and spare supplies will be kept in the health office and after-school program. Gauze and gloves will be supplied for the classroom and PE. 2. [Name] has orders to use a wheelchair and or mobility scooter as needed on campus. 3. [Name] may come to school with an IV in place. It will be wrapped up securely and is typically located on her hand.   **ATTENDANCE**   1. [Name] absences will be medically excused if related to her bleeding disorder and her asthma for up to 3 days without a medical note. After 3 days, her absences may be excused, but not medically, unless parents bring in a doctor’s note.   **EXERCISE & PHYSICAL ACTIVITY**   1. The student shall be permitted to participate fully in physical education classes except as indicated in the student’s medical orders. [Name] should avoid contact sports and climbing unassisted per her medical team. 2. [Name] should be closely supervised on the playground. Please keep a safe distance to be able to redirect but not to shadow too closely. 3. PE instructors must have a copy of the *emergency action plan* and be able to recognize and assist with the treatment of any injury. 4. Responsible school staff will make sure that the spare gloves, and gauze, is always available in class and PE.   **WATER AND BATHROOM ACCESS**   1. The student shall be permitted to have unrestricted and immediate access to bathroom, water and health office.   **MONITORING AND MEDICATION ADMINISTRATION**   1. When the student asks for assistance or any staff member believes the student is showing signs of bleeding, the staff member will immediately seek assistance from the health clerk, nurse, or trained staff while making sure an adult stays with the student at all times. Never send the student alone with symptoms of bleeding or trouble breathing. 2. Any staff member who finds the student having signs of diminished consciousness will immediately call 911 and contact the health office. The health clerk or trained personnel will follow the classroom health care plan and emergency plan.   **FIELD TRIPS AND EXTRACURRICULAR ACTIVITIES**   1. The student will be permitted to participate in all school sponsored activities and field trips without restriction and with all of the accommodations and modifications, including necessary supervision by identified school staff, set out in this plan. She will not be excluded from activities without prior written consent from parents, unless it conflicts with a current doctor’s note. 2. Parents may accompany the student on field trips or any other school activity if they desire. 3. Trained staff and/or school nurse will be available on site at all school sponsored field trips, and extracurricular activities, will provide all usual aspects of care and will make sure that the students medications and supplies travel with the student.   **TESTS AND CLASSROOM WORK**   1. If the student is having symptoms such as dizziness, fatigue, etc., the student will be permitted to take the test at another time without penalty. 2. If the student needs to take breaks to drink water or use bathroom, during a test or other activity, the student will be given extra time to finish the test or other activity without penalty. 3. The student shall be given handouts/instructions to help make up any classroom instruction missed due to medical care without penalty. 4. Allow the student to make up any work if missed due to medical care. The number of days absent plus one will be allowed for make-up. 5. All make-up work needs to be turned in 5 days prior to the end of the trimester in order to received credit. 6. The student shall not be penalized for absences required for medical appointments and/or for illness. The parent will provide documentation from the treating health care professional if otherwise required by school policy.   **COMMUNICATION**   1. Parents will notify the health office of changes in her health condition, medical orders and provide a current copy of medical orders to health office prior to first day of school and throughout the school year if orders change. 2. Parents will notify attendance office of absences and specify if they are medically related. 3. The teacher, health clerk, and trained staff will provide reasonable notice, 2 weeks, to parents and school nurse when there will be a change in planned activities such as exercise, playground time, and field trips. 4. Each substitute teacher, school nurse, and health clerk will be provided with written instructions regarding student’s medical care.   **EMERGENCY EVACUATION & SHELTER- IN-PLACE**   1. In the event of an emergency evacuation or shelter-in-place situation, the students 504 Plan and medical orders will remain in full force and effect. 2. The school nurse or trained staff will provide medical care to the student as outlined by this Plan and students *care plans*. They will be responsible for transporting the student’s medications and supplies, will attempt to establish contact with the student’s parents and provide updates and will receive information from parents regarding the student’s medical care.   **911 AND PARENTAL NOTIFICATION REQUIRED IMMEDIATELY FOR THE FOLLOWING:**   1. Serious injury (large wound, head injury, etc.) 2. A large or excessive amount of bleeding lasting more than 10 minutes with firm pressure applied. 3. Large or excessive amounts of bleeding. 4. Pale skin, clammy (cool and sweaty), decreased level of consciousness, or any signs of distress. |  | **Desired Outcome:**  **Date:** 09/05/20  Overall desired outcome:  Maintenance of safety and stabilization of any medical concerns.  Provide [Name] the same opportunity to access the academic curriculum and demonstrate comprehension as students without disabilities. |

[NAME] SCHOOL DISTRICT

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**COMMITTEE SUMMARY**

# **Name:** **DOB: Grade:**

## School: Student Permanent Number:

### Participating Committee Members

Parent/Guardian Date Administrator/Designee Date

Parent/Guardian Date Student Date

Teacher Date School Nurse Date

Member/Title Date Member/Title Date

**Summary of Discussion**:

Parent Rights given.

Introductions made.

Discussed purpose of the meeting.

Reviewed 504 accommodations, health care plan, emergency plan, and made a few changes as necessary.

Discussed field trips and having good communication between staff, nursing, and parents.

Discussed concern with ball play and modified the care plan.

Discussed emergency accommodations and risk for safety concerns and how to accommodate her on the playground. Discussed needing a 1:1 for recess/lunch time. Principal working on getting 1:1 supervision for lunchtime.

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Signature of Person Completing Form Date