

Section 504 Checklist for Students with Medical Disabilities

Student _____ **Grade** _____ **I.D. #:** _____

School _____ **Date** _____

- | Yes | No | NA | |
|--------------------------|--------------------------|--------------------------|---|
| | | | Disabling condition that affects major life activity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | This student has a potentially life threatening medical condition,
_____. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The life system of _____ is affected which creates eligibility for Section 504 protection. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The onset of the reaction (anaphylactic shock, hypoglycemia, hyperglycemia) can be sudden and fatal within minutes/hours. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The reaction must be treated immediately. |

- | Yes | No | NA | |
|--------------------------|--------------------------|--------------------------|---|
| | | | Evaluation criteria (basis for determining the disability) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation from Physician re: Medical Diagnosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

- | Yes | No | NA | |
|--------------------------|--------------------------|--------------------------|---|
| | | | Impact of Disability |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Restricted opportunity to participate in the educational program due to a potentially life threatening condition. (Must be documented by physician) |

NECESSARY ACCOMODATIONS: (check all that apply)

- | Yes | No | NA | |
|--------------------------|--------------------------|--------------------------|---|
| | | | 1. Emergency Action |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Completed Individualized Health Care Plan-Emergency Plan Attached |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Doctor's orders for medication/treatments on file |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medication/Equipment at school |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emergency "kit" (medication, IHP, and DR's orders)
Location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emergency Health Care Information for Substitute teachers(s) given to _____ for placement in sub folder |

- | Yes | No | NA | |
|--------------------------|--------------------------|--------------------------|---|
| | | | 2. Staff Training |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Staff training (nurse) Date: _____ by: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emergency medication training for administration of _____
(by nurse) Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Review with staff working closely with student (by nurse) Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

- | Yes | No | NA | |
|--------------------------|--------------------------|--------------------------|--|
| | | | 3. Classroom Management of Medical Condition |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teacher recommendations given to teacher |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teacher(s) will contact parent(s) regarding school projects involving food/allergen. |

Yes No NA **4. Snacks/Parties/Treats/Cafeteria (In the case of special diets)**
 The child will only consume food considered safe by the food allergic child's parent(s).
 Parent(s) will provide a supply of safe snack/party foods to be kept on hand at school for their child.
 The snacks will be stored by the teacher.
 Parent(s) and teacher(s) will be encouraged to communicate openly.
 Other: _____
 Note: OCR maintains that districts are not required to supply snacks for student with diabetes, but time must be given for student to obtain snack.

Yes No NA **5. Field Trips**
 Parent(s) will be notified of all field trips.
 Parent(s) requests to accompany class on all field trips.
 Persons trained in medication administration will take "emergency kit" and cell phone on field trips.
 Other: _____

Yes No NA **6. Bus Transportation:**
 Student rides the bus and transportation department has copy of IHP.
 Specialized training for bus drivers needed.
 Other: _____

Yes No NA **7. Fire/Emergency drill procedures:**
 In event of a fire drill or fire, _____ will take the emergency "kit" outdoors.

Yes No NA **8. Child currently participates in Tangipahoa Parish School System's after school activity(s) and program(s):** _____

IHP will be distributed to after school TPSS activities/programs by nurse.
 Training is needed for the staff and will be provided by nurse.
 PARENT(S) ARE RESPONSIBLE FOR ALERTING ANY SPECIAL ACTIVITIES/PROGRAMS THAT THE CHILD MAY PARTICIPATE IN (examples: sports, clubs, trips)

Yes No NA **9. Other:**
 When moving to a new school, PARENT(S) are responsible for providing school copies of all needed information. Parent(s) should keep a copy of all key forms for their records.

10. Emergency Contact Instructions:
 a. Call the student's home. If unable to reach parent/guardian: _____

 b. Call the student's parent/guardian's cell or work phone. If unable to reach parent/guardian: _____

c. Call the other emergency contacts listed below.

Parent's/Gaurdian's Name Home Phone Number

Work Phone Number Cell Phone Number

Parent's/Gaurdian's Name Home Phone Number

Work Phone Number Cell Phone Number

Other Emergency Contacts:

Name Home Phone Number

Work Phone Number Cell Phone Number

Name Home Phone Number

Work Phone Number Home Phone Number

Student's Physician(s):

Name Phone Number

Signatures

Section 504 Chairperson _____ Nurse _____

Parent(s) _____ Principal _____

Teacher(s) _____

NOTE: Attach to 504 Plan

cc: Parent, Teacher, Office Personnel, Bus Driver(s), 504 Coordinator