

Haddon Heights School District  
School Name  
Address  
Phone Number  
Fax Number

Date:

Re: 504 Accommodations

Dear Parent/Legal Guardian:

This letter is to provide you with written notice that a reevaluation of your child's eligibility under Section 504 will be conducted at a Section 504 Committee Meeting. *Child's name* was under a 504 plan during the 2017-2018 School year. Under the 504 Section 504 of the Rehabilitation Act of 1973, *child's name*, must be reviewed by the 504 Committee. If you would like to meet to discuss changes to the plan, please bring a copy of your child's current medical diagnosis and list from the prescribing physician of all currently prescribed medications. If you do not need to meet and there are no changes required for your child's 504, please send in a copy of the following: current diagnosis and list of prescribed medications from the current physician. Please note that all of the above information must be provided to the school in order for your child's 504 plan to continue for the upcoming school year. We have enclosed a description of Section 504 and the rights you and your child are entitled to under Section 504 of the Rehabilitation Act of 1973. *Please fill out the attached meeting participation form below.*

The meeting is scheduled for:

**Date:**

**Location:**

If you have any questions please feel free to contact me or Michele Mendenhall, Supervisor of Pupil Personnel Services, at 856-547-1920. Thank you.

Sincerely,

504 Coordinator

Notice of Considerations:

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Student I.D. #: \_\_\_\_\_

Please check and return to the Building Section 504 Coordinator or designee named below:

- I have reviewed the accommodations and no changes are requested or needed at this time.
- I have reviewed the accommodations and would like to meet with you to discuss changes to the accommodations.
- I have reviewed the accommodations and have made changes to the plan, but I do not require a meeting.
- My child no longer requires a 504 plan.
- I have reviewed the accommodations and no changes are requested or needed at this time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

- I acknowledge that I will provide a current medical diagnosis and list of all prescribed medications to the district in order to continue my child's 504 plan.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you have questions or concerns, please contact:

Building Section 504 Coordinator/Designee: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Office Use:

Date Second Notice: \_\_\_\_\_ Method of Notice: \_\_\_\_\_

Date Third Notice: \_\_\_\_\_ Method of Notice: \_\_\_\_\_