William Floyd Union Free School District
of the MASTICS – MORICHES – SHIRLEY
240 Mastic Beach Road, Mastic Beach, NY 11951

Kevin M. Coster
Superintendent of Schools

Michele Gode, Ed.D.
Principal, 504 Chairperson

Dear Parent/Guardian of:

For your convenience, attached are the necessary medical forms to begin the 504 process. Please sign the medical release form and submit both forms to your child's physician. The completed physician's report form must be returned to the nurse's office, who will in turn submit it to the Committee for review. You can fax the completed forms to the nurse's office at 874-1411. You will then be notified by letter of the date of the 504 Committee meeting.

If you have any questions or concerns, please contact the East Office at 874-1191.

Sincerely,

Michele Gode

Michele Gode, Ed.D.
Principal, 504 Chairperson

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504 Chairperson
William Paca Middle School
338 Blanco Drive.
Mastic Beach, NY 11951

TO BE COMPLETED BY SCHOOL OFFICIAL

New Referral: Yes____ No____ Existing 504 Anniversary Date:_____

School Physician: _____Date: _____

□ Condition eligible for 504 consideration

□ Condition ineligible for 504 consideration

Student: _____ D.O.B._____ Grade:_____

The student listed above has been under my treatment for the past _____ years/months.

Diagnosis & DSM-IV code**:**_____**REQUIRED**

Date diagnosis initially formulated: _____

This condition is: Chronic_____ Acute_____ and is expected to affect the child for _____years/months/days.

Is the student homebound? Yes_____ No_____

Will this condition affect the student's ability to participate in social events? Yes_____ No_____

If yes, how? _____
_____

Will this condition affect the student's ability to participate in physical activities/ gym? Yes_____ No_____

If yes, how?_____
_____

Will this condition affect the student's educational program and/or their ability to learn? Yes_____ No_____

If yes, how?_____
_____

Will this condition affect the student's ability to attend school? Yes_____ No_____

If yes, how?_____

If so, how much additional time would you estimate would be required away from the educational setting?
_____

Please provide a brief historical description of the condition and any additional information related to accommodations needed for the student's educational success.
_____
_____
_____

Sincerely,

_____
Physician's Signature Physician's Stamp

Licensure Number: _____ Area of Licensure/Certification: _____ Exp date: _____

Highest School Degree_____

Please print name: _____ Date:_____ Phone Number:_____

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William Floyd School District
Mastic Beach, NY 11951

Request for Records

Date: _____

I, _____ hereby give permission to
(Parent/Guardian)

_____ to release all medical and/or
(Physician)

Psychiatric and any other pertinent records pertaining to
_____
(Patient)

To the William Floyd School District, 240 Mastic Beach Road, Mastic Beach, NY 11951.

_____
Signature of Parent/Guardian