504 Plan Instructions

Patients Name: _____ Date of Birth: _____

Please answer the following questions to help us fill out the 504 plan for your child:

1. What accommodations does your child need (i.e. longer testing time, quieter testing environment, movement breaks, etc)?

_____

_____

2. Which diagnosis or symptoms do you feel justify a 504 plan?

_____

3. Who advised you to get the form completed (i.e. counselor at school, teacher, etc)?

_____

4. Is there anyone else filling out a 504 plan for your child?

Name: _____ May we contact: Yes No

PEDIATRIC AND ADOLESCENT ASSOCIATES
3050 HARRODSBURG ROAD
LEXINGTON, KY 40503
(859) 277-6102 F: (859-977-3033)