



# PEMBERTON TOWNSHIP SCHOOLS

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## 504 Parent Referral Form

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Counselor: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

I. Describe the nature of the handicap and how your child's current academic program discriminates against them.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Describe how the student's handicap affects a major life activity (such as walking, seeing, speaking, breathing, learning or working). Please attach any supporting documentation.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. What, if any, specific accommodation/modifications are you seeking?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In order to assist our committee in properly evaluating your request, we ask that you return this form with a professional evaluation to your child's guidance counselor.

1. Professional's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

OR

2. Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_