

SAU 24
NOTICE OF 504 TEAM MEETING

| | | |
|------------------------------|--------|------|
| Student's Name: | DOB: | Age: |
| School: | Grade: | |
| Parent/Guardian: | | |
| Case Manager/Contact Person: | | |

Date: _____

Dear: _____

A 504 Team meeting has been scheduled for your child on:

Date: _____ Time: _____ Place: _____

The purpose(s) of the meeting is:

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|---------------------------------------|-------------------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | Initial Referral/Eligibility | <input type="checkbox"/> | Initial Plan Development |
| <input type="checkbox"/> | Plan Review | <input type="checkbox"/> | Evaluation/Re-evaluation |
| <input type="checkbox"/> | Parent Request | <input type="checkbox"/> | Transfer Student |
| <input type="checkbox"/> | Disciplinary Removal | <input type="checkbox"/> | Other |

As the parent(s)/guardian of a child or as an adult student who has or may have a disability, you are encouraged to participate in the 504 Team meeting. Additional participants who have knowledge or special expertise regarding the child may be invited at the discretion of the parent or district. Members and participants invited to attend the 504 Team meeting may include the following:

| Title: | Name: |
|---|--------------|
| <input type="checkbox"/> 504 Coordinator: | _____ |
| <input type="checkbox"/> Administrator: | _____ |
| <input type="checkbox"/> Regular Education Teacher: | _____ |
| <input type="checkbox"/> Evaluator(s): | _____ |
| <input type="checkbox"/> Child or Adult Student: | _____ |
| <input type="checkbox"/> Other: | _____ |

If you have questions or cannot attend at the scheduled time, please call _ at _.

(A copy of the Notice of Procedural Safeguards will be provided upon request.)