Date: _____

RE: Evaluation Request for _____ D.O.B._____

Dear School Administrator:

I have assessed the child whose name appears above. Based on the results of this assessment, I have identified the following areas of concern: _____

_____

_____

At this time, I would like to formally join this child's legal guardian in requesting a full special education evaluation, including (but not limited to) a full speech/language pathologist's assessment, an occupational therapy assessment, full cognitive testing, and complete academic testing.

Please send a copy of each FULL assessment (NOT A SUMMARY) to the address above. By signing in the spaces indicated below, this child's legal guardian is both requesting and consenting to the special education evaluation and also agreeing to release all the records related to this special education evaluation to my office.

Of course, you are aware of the many federal regulations stemming from the Individuals with Disabilities Education Act (IDEA), including the requirement that you will complete this evaluation and have an IEP meeting with the legal guardian of the child listed above within 60 school days (34 C.F.R. § 300.301), or you will inform the family in writing the reasons for the denial and the procedure for appeal within 14 school days (23 IL Admin. Code 226.110(c)(3)). We will continue to follow the child named above in our clinic, and trust that we will hear from the family at an upcoming appointment that the evaluation process has begun.

If I can be of any assistance to you, or if you have any questions regarding this matter, please contact me at the numbers listed above.

Respectfully,

_____ _____

(Provider for the child named above) Date signed

Parental Consent and Request for Case Study Evaluation:

By signing below, I hereby request and give my consent for the special education evaluation of my child.

_____ _____

(Legal guardian for the child named above) Date signed

Release of Records:

I hereby consent to have my child's evaluation and assessment reports and test protocols released to the above named physician. I understand that this consent is valid for one year from the date of signature, but may be revoked at any time if revocation is placed in writing. Such revocation shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and copy the information to be disclosed, and that the confidentiality of my records is protected by law. Further disclosure of this information will require my prior written consent, unless otherwise permitted by Federal and State law.

Legal guardian for the child named above (if child is under 18 years old)

Date: _____Signature:_____

Signature of Child (if child is age 12 or over)

Date: _____Signature:_____