

Date of referral _____
Date Assessment Plan _____
Delivered/Mailed _____
Date of Receipt _____
Date IEP Due _____

CONSENT FOR ASSESSMENT

To Parent/Guardian of _____ Birthdate _____

District _____ School _____

Language(s) of Home _____ Language(s) of Pupil (Primary) _____ (Other) _____ EO _____ ELL _____

The purpose of this assessment is to determine individual education needs. Assessment in areas checked below will be completed by appropriately qualified staff and, when appropriate, with an interpreter for the student's primary language. The assessment may include student observation in class or other settings, interview with you and a review of any reports you have authorized or that already exist in current school records.

Suspected disability _____

Assessment: Initial _____ Three-year review _____ Transfer _____ Other _____

ASSESSMENT AREA	DESCRIPTION OF MATERIALS AND PROCEDURES	PERSONNEL
<input type="checkbox"/> ACADEMIC PERFORMANCE	PURPOSE: To determine skill levels in reading, mathematics, and written language.	<input type="checkbox"/> Sp. Education Teacher <input type="checkbox"/> School Psychologist <input type="checkbox"/> Other: _____
<input type="checkbox"/> SELF-HELP, SOCIAL, AND EMOTIONAL STATUS	PURPOSE: To determine the general level of skills in independent functioning, social skills, adaptive and social behavior.	<input type="checkbox"/> School Psychologist <input type="checkbox"/> Other: _____
<input type="checkbox"/> MOTOR ABILITIES	PURPOSE: To determine skill levels in large and/or small muscle activities.	<input type="checkbox"/> School Psychologist <input type="checkbox"/> Other: _____
<input type="checkbox"/> LANGUAGE AND SPEECH	PURPOSE: To determine skill levels in understanding or using spoken language.	<input type="checkbox"/> Language/Speech Pathologist <input type="checkbox"/> Other: _____
<input type="checkbox"/> GENERAL ABILITY	PURPOSE: To determine general learning and ability.	<input type="checkbox"/> School Psychologist
<input type="checkbox"/> HEALTH, DEVELOPMENT, VISION AND HEARING	PURPOSE: Determine health/medical factors which may impact education or participation. Vision and hearing screening will be completed for all initial assessment and three-year review.	<input type="checkbox"/> School Nurse <input type="checkbox"/> Other: _____
<input type="checkbox"/> AUDIOLOGICAL ASSESSMENT	PURPOSE: These instruments measure the nature and degree of possible hearing loss. Tests may include measures of how well a student hears, understands, and listens to speech.	<input type="checkbox"/> Audiologist
<input type="checkbox"/> ALTERNATIVE MEANS	PURPOSE: This is a multi-purpose category of assessment. Testing may be required to assess skills with the use of an interpreter or using modifications.	<input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> VOCATIONAL ABILITIES/ INTERESTS	PURPOSE: These tests and procedures will provide vocational interests and needs.	<input type="checkbox"/> _____
<input type="checkbox"/> OTHER AREAS OF ASSESSMENT: () Family History; () Other _____		

Steps taken to accommodate assessment in student's primary language or mode of communication: Does not apply

Describe: _____

PLEASE CHECK THE FOLLOWING ITEMS IF APPROPRIATE:

Other evaluations that should be considered/reports to be reviewed _____

I would like additional assessment of my child in the following areas: _____

If you have any questions about this Assessment Plan, please call the following person before signing:

Name _____ Phone _____

PARENTAL CONSENT FOR ASSESSMENT

I understand the assessment plan and I have received a copy of the parental rights. I understand that no placement will result from this assessment without my consent.

Yes, I give my permission to conduct this assessment as described.

No, I do not give my permission for this assessment.

Parent Signature _____ Date _____

Address _____ Phone _____

White: Student file Canary: Implementor's Copy Pink: Parent