

Okeechobee County School Board Consent for Formal Individual Evaluation

Date _____
Student Name _____
School _____

Dear _____

Your child has been referred for an evaluation to help plan an educational program to meet his/her needs.

The referral was based on a review by school personnel of your child's educational records along with recommendations of teachers and other personnel who are familiar with your child.

The following checked (✓) educational options have been considered or used with your child:

- | | |
|--|---|
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Change in Level of Instruction |
| <input type="checkbox"/> Change in Instructional Methods | <input type="checkbox"/> Community Agency Referral |
| <input type="checkbox"/> Tutoring | <input type="checkbox"/> Dropout Prevention Program |
| <input type="checkbox"/> Behavior Management | <input type="checkbox"/> English for Speakers of Other Language |
| <input type="checkbox"/> Other _____ | |

Other factors relevant to this notice are:

The option(s) were determined insufficient to meet the educational needs of your child and have been rejected as the primary methods of assisting your child.

A comprehensive evaluation provided by an educational specialist includes specific tests and reports based on your child's needs. The evaluation may include those areas indicated below:

- CLASSROOM OBSERVATIONS:** To assess student response to classroom activities.
- DEVELOPMENTAL:** To assess cognitive, communication, social-emotional, motor, and adaptive skills (<6 yrs. old).
- PSYCHO-EDUCATIONAL:** May include assessment of any of the following: intellectual, academic achievement, cognitive processing, adaptive, behavior, or emotional.
- VISION:** To assess visual ability.
- AUDIOLOGICAL:** To assess hearing ability.
- SPEECH/LANGUAGE:** To assess language ability, articulation skills, fluency and voice quality.
- SOCIAL AND DEVELOPMENTAL HISTORY::** To access family, birth, medical, and behavioral history.
- REVIEW OF ALL STUDENT RECORDS INCLUDING RECORDS PERTAINING TO INTERVENTION HISTORY THROUGH MTSS PROCEDURES.**
- MOTOR/PHYSICAL:** To assess fine and/or gross motor skills.
- MEDICAL:** To assess physical status which may influence learning and may include pediatric, psychiatric, physical and/or neurological evaluation.
- GIFTED CHECKLIST**
- OTHER:**

As a parent of a student with disabilities you have certain protections under the attached IDEA Procedural Safeguards. As a parent of a gifted student you have certain protections under the attached Gifted Procedural Safeguards. For further information, explanations, or copies, please contact the ESE Director or Guidance Counselor.

Okeechobee County bills Medicaid for fee for service therapies. There are no charges to the parent for any service billed.

Contact your Guidance Counselor at _____ or the Exceptional Student Education office at 462-5000, ext. 255, if you have any questions.

Please sign and return to the Guidance Counselor.

I have read and understand my rights in regard to the proposed evaluation.

Check (✓) all that apply:

- I give my permission for testing and I have received a copy of the Procedural Safeguards.
- I give my permission for release of records for Medicaid eligibility and billing purposes.
- I do not give my permission for testing, but I have received a copy of the Procedural Safeguards.
- I request a conference to discuss this evaluation before granting my permission.

Parent Signature

Date

Medicaid	
Child's Medicaid # _____	_____
Child's Social Security # (Optional) (copy of card should be provided)	_____

Date Received By _____
School: _____

Record of Contact Attempts: For Office Use					
1. _____	2. _____	3. _____			
(date) (type) (results)	(date) (Type) (Results)	(date) (Type) (Results)			
By: _____	By: _____	By: _____			