

Mid-Valley Special Education Cooperative

1304 Ronzheimer Ave St. Charles, IL 60174 (331) 228-4873 ; (331) 228-4891 Fax

Serving children and families of the Batavia, St. Charles, Geneva, Kaneland and Central Community School Districts

Mid-Valley Program Referral Information

Please complete the requested information and mail, email (Bonnie.Carlson@d303.org) or fax (above) to the MV office. The information will be forwarded to a program coordinator, who will follow up with district contact regarding support needed.

Date of Request:

First	Middle	Last	DOB	Age	Grade	Disability	Home District
Current Educational Services/School			Last Annual Date	Last Evaluation Date		SIS # Medicaid #	
Parent/Guardian Name(s)			Primary Phone	Work/Cell Phone		Emergency Contact/Phone	
Home Address			Language	F/R Lunch	Ethnic/Race	Gender	
District Contact /Designee			Phone	E-Mail			
Name of Possible MV Program			Move-In Student?	Does the student have a FA/BIP?			

Please indicate the anticipated time frame to determine the need for a Mid-Valley placement:

___ Upcoming School year ___ 6-8 weeks ___ 4-6 weeks ___ 2-4 weeks ___ URGENT/Immediate

Anticipated date, time, location of Placement Meeting/Discussion with parents: _____

Student Concerns

Please describe the student concerns for which you are seeking MV assistance:

Please describe the level of service and why a different placement is being considered.

Are the parents in agreement with this possible placement?

Are there other placements you are considering? If yes, which ones?

Program Visits

Would you like to visit the MV program? If so, when?

- Prior to the placement meeting
- Following a suspended placement meeting
- Other: _____

Who will be visiting?

- Parents (with district staff)
- Staff only
- Other: _____

If parents will be visiting, who will be accompanying the parents on the visit?

Days/Preferred Times for the Visit:

Meetings

Would you like to schedule an informal meeting/student observation with Mid-Valley program staff? **Y** **N**

If so, please specify preferred days / times: _____

District Special Education Administrator: (signature) _____

Return completed form to the Mid-Valley Office. It will be distributed to the appropriate teachers and administrators.

Date Received: _____