

Mid-Valley Special Education Cooperative

1304 Ronzheimer Ave. St. Charles, IL 60174 (331) 228-4873 fax (331) 228-4874 tty: (630) 513-7114
Serving the children and families of the Batavia, Kaneland, Geneva, Central and St. Charles Community School Districts

Request to Access Classroom(s) or Personnel for Special Education Evaluation and/or Observation Purposes

Student name: _____ DOB: _____

School attending: _____ Grade: _____

The following information must be completed by individuals requesting to access a school building, facility, and/or educational programs or to interview Cooperative personnel or the student named above for the purpose of assessing the student's special education needs. Please complete this form and return it to the classroom where the student is enrolled, who will forward it to the Program Coordinator. He or she will contact you to coordinate your visit:

Observations are limited to one hour or one class period per school quarter, unless otherwise arranged.

Parent's Independent Evaluator or Other Qualified Professional (Complete this section if the person making the request is not the parent/guardian.)

Name: _____ Agency/Company: _____

Phone: _____ Email address: _____

Address: _____

My professional training and/or licensure or certification, if applicable, is (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Teacher, certified in the areas of: _____ Illinois certified? <input type="checkbox"/> Y <input type="checkbox"/> N | |
| <input type="checkbox"/> Clinical Psychologist | <input type="checkbox"/> School Psychologist |
| <input type="checkbox"/> Licensed Clinical Social Worker | <input type="checkbox"/> Licensed Social Worker |
| <input type="checkbox"/> School Social Worker | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Speech/Language Pathologist |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Certified School Nurse |
| <input type="checkbox"/> Other qualified professional (list credentials): _____ | |

I have been requested by the above named student's parent/guardian to conduct an evaluation of the student for the purpose of: _____

As part of this evaluation, I am requesting the following for the length of time noted (check all that apply):

Observation of student in the following classroom(s)/setting(s): _____
_____ Duration: _____

Opportunity to interview the following personnel believed to work with the student: _____
_____ Duration: _____

Opportunity to interview the student.

I will need more than one hour or one class period for my visit for the following reason(s): _____

Student records, as noted in the attached, signed Authorization to Release Student Record Information.

Acknowledgement *(To be completed by the person making the access request.)*

I understand that the Cooperative will allow me reasonable access to the school, school facilities, or educational programs or individual(s) I have requested as related to the purpose of my visit. I understand that visits may have to be rescheduled due to classroom disruption. I further understand that during my visit, I must honor all students' confidentiality rights and refrain from any re-disclosure of such records.

Individual Requesting Access Signature

Date

Parent/Guardian Verification *(Must be completed whenever an independent evaluator or other qualified professional requests access.)*

I, _____, am the parent/guardian of the above-named student, and I confirm that I have requested an evaluation of my child by the individual named herein, for the stated purpose(s). If requested above, I consent to my child being interviewed by the named evaluator as part of this visit understanding that the Cooperative has not conducted a background check on the evaluator. I have no reason to believe the evaluator poses a safety risk to my child or others. I further understand and agree that it is my responsibility to notify the Cooperative in writing if I end my working relationship with the named evaluator prior to the completion of the tasks outlined herein and that the Cooperative otherwise will work with the evaluator to provide reasonable access to the school, school building, school facility, personnel, or my child at mutually agreed upon times and in a manner that is least disruptive to the school setting or my child's academic program.

Parent/Guardian Signature

Date

DATED: