**CONSENT FOR RECORD REVIEW**

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Child’s Full Name DOB Teacher/School

For reevaluation purposes, I acknowledge that that a full, individual evaluation is not needed to determine that my child/student continues to be a child/student with an educational disability. I have been informed of the reasons that a full, individual evaluation is not needed. I understand that I may request further assessment should I feel it is needed.

For reevaluation purposes, I acknowledge and agree that a record review is sufficient for determining that my child/student continues to be a child/student with an educational disability. I have been informed of, understand, and agree with the reasons that a record review is sufficient.

In compliance with laws regarding the completion of record reviews, the following procedures/assessments are requested as part of the record review process for your child/student:

\_\_\_\_\_\_vision screener conducted by the school nurse

\_\_\_\_\_\_ hearing screener conducted by the school nurse

\_\_\_\_\_\_communication screener conducted by the speech pathologist

\_\_\_\_\_\_classroom observations

\_\_\_\_\_\_record review

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I have been advised in my native language or other mode of communication and understand the contents of this consent. A copy and explanation of procedural safeguards has been provided to me as required by law. I understand that my consent is voluntary and may be revoked at any time. Should I revoke consent I understand that it is not retroactive.

I understand all information presented and give my consent for all area(s) listed above.

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Parent/Student Signature Date