PERMISSION FOR SCREENING BY A TEACHER AND/OR SPECIALIST FOR INSTRUCTIONAL STRATEGIES

I give my permission for the:

_____ Physical Therapist ____ Teacher for students who are Deaf or Hard of Hearing

_____ Occupational Therapist ____ Teacher for students who are Blind or have Low Vision

_____ Assistive Technology Point Person

to perform a classroom observation/screening on my child. Results of the screening may suggest the need for simple interventions or may indicate the need for a formal evaluation. If formal evaluation is indicated you will be contacted to sign the appropriate permission for evaluation.

_____ _____

Parent/Guardian Signature Date

Student:_____ Date of Birth:_____ School: _____

Person making referral: _____

Use the back of the page if more space is needed.

Concerns:

List interventions currently in place or attempted and the results obtained:

How long have these interventions been implemented?

Suggestions (To be filled out by person or persons making observation):

cc to: Area Program therapist(s), Teacher for the blind and low vision, Teacher for the deaf and hard of hearing, and/or AT point person, Parent, student file, teacher

Revised 9/24/14