Wakulla County Schools
Exceptional Student Education

Parent Notice and/or Consent for Re-Evaluation

To the Parent(s) of:_____DOB:_____ GRADE:_____

SCHOOL:_____TEACHER: _____

ESE PROGRAM(S):_____

A re-evaluation review is required for each student with a disability at least every three years, or more frequently if conditions warrant, or if the child's teacher or parent requests a re-evaluation. The IEP team reviewed information available in all areas addressed in the initial evaluation or subsequent re-evaluations of your child. This information includes the following: □ evaluation data gathered since the initial evaluation or previous re-evaluation; □ information provided by teachers/staff; □ current classroom-based assessments and observations; □ information provided by family members; □ other_____

Signatures of attendees at Re-evaluation Team meeting: Date_____

*LEA*_____ *Evaluation Specialist*_____

*General ED teacher*_____ *ESE Teacher*_____

*Parent*_____ *Other*_____

The purpose of the re-evaluation is to:

1. Determine if your child continues to have a disability and continues to need special education and related services.
2. Assess your child's present level of performance and educational needs;
3. Determine if any additions or modifications are needed to enable your child to meet the annual goals in his/her individual educational plan and to participate, as appropriate, in the general curriculum;
4. Gather additional data if needed.

We have considered the following options for your child: (1) a 3 year re-evaluation; (2) a more frequent re-evaluation; and (3) no assessment recommended. **We chose option_____ for your child**. The other options were rejected as they did not meet the needs of your child at this time. If other factors were relevant to this proposal, these include the following:_____. Based on this review, the checked areas described below are recommended. Additional evaluations may be administered if deemed appropriate by the evaluators/evaluation team.

{□} Developmental Evaluation (birth to age 6)
{□} Physical Therapy Evaluation
{□} Occupational Therapy Evaluation
{□} Orientation and Mobility (O & M)
{□} Social/Developmental History
{□} Assistive Technology Evaluation-include AT referral
{□} **No Assessment Recommended**
WHY?_____

{□} Speech-Language Screening/Evaluation
{□} Intellectual Evaluation
{□} Academic Achievement
{□} Behavior Skills
{□} Vision Screening/Evaluation
{□} Hearing Screening/Evaluation
{□} Adaptive Behaviors
{□} Other_____

The school will contact you to arrange a time for you to discuss the re-evaluation results. Please check the appropriate space provided, sign, date, and return to: _____

{□} Yes, I consent to the above recommendations **{□} No, I do not consent to the above recommendations.**
{□} I request a conference before giving permission for the re-evaluation.

I have received and reviewed the Procedural Safeguards and understand my rights under the Individuals With Disabilities Education Act of 2004:

_____ _____
Signature of Parent/Legal Guardian/Surrogate/Student (if 18 years of age or older) **Date**

You have specific rights and protections concerning this proposal that are described in the attached Summary of Procedural Safeguards (Rule 6A-6.03311, FAC).Further explanation of rights and copies may be obtained from the ESE Director or school counselor or upon request.

If you have any questions or input, please call:	Record of contact attempts.			OFFICE USE
	1. Date:	Type:	Results:	
	2. Date:	Type:	Results:	
Phone:	3. Date:	Type:	Results:	
School.	By:			