Union County Educational Services Commission
Request for Child Study Team Evaluations / Services

Student Information

Student Name: _____ **School:** _____

Gender: M / F **Date of Birth:** _____ **Grade:** _____ **Classification** (*if applicable*)**:** _____

Parent/Guardian Information

Guardian(s) Name(s):_____ **Phone:** _____

Address: _____ **City:**_____ **Zip:** _____

Has parental consent been obtained for the evaluations? Yes_____ No_____ Date:_____

Are parents aware that evaluations will be conducted by independent contractor(s)? Yes____ No_____

Evaluation/Service Request Information

Evaluation(s) Requested: Psychological ____ Educational ____ Social ____ Speech _____ Other: _____

Reason for Eval: Initial ____ Re-evaluation ____ Preschool Exit ____ Transition Planning: ____ Other: _____

Evaluation Reports Needed by *(date)***:**_____ **Can Evaluations be conducted evenings/weekends:** Y / N

Meeting Attendance Requests*(Please include disciplines and possible dates/times)***:** _____

Scheduling: Consultants should contact _____ for testing at _____
(Name) *(Phone and/or email)*

Other District Requests/Concerns *(including specific assessment requests,* ***bilingual*** *evaluator requests or student information)* **:**

_____

District Information

School District Name & Address: _____

_____

District Educational Contact: Name: _____ Title: _____

Phone: _____ Email: _____

_____ _____ _____
Sending District Representative Signature **Title** **Date**

The above signature indicates consent for Union County Educational Services Commission to complete all indicated evaluations at the rate(s) indicated on the attached fee schedule.

UCESC Office Use Only

Consultant(s) Name(s) **Discipline** **Contact Information** **Date Assigned**

_____

_____

_____

Date of Case Completion: _____ *Billed:* _____