LONGVIEW PUBLIC SCHOOLS
Creating the future today

SPECIAL SERVICES INFORMATION PACKET

Welcome to the Longview School District. You and your child are encouraged to be active participants in the education process. You know your child best, and we welcome and value the information and ideas you bring.

Your school will review information from the previous district to confirm eligibility. Your child's placement in the Special Education Program may be temporary. Within thirty (30) days of admission, you will be notified of your student(s) suggested service model.

The Family Educational Rights Privacy Act (FERPA) allows a school district to re-disclose educational records to schools in which the student enrolls or intends to enroll. This includes approved nonpublic agencies and other private schools.

The parent or eligible student has a right to:

1. Inspect and review the student's education records;
2. Request amendment of the student's education records to ensure that they are not inaccurate, misleading, or otherwise in violation of the student's privacy or other rights;
3. Consent to disclosures of personally identifiable information explained in the student's education records, except to the extent that the Act and the regulations in this part authorize disclosure without consent;
4. File with the U.S. Department of Education a complaint under Section 99.64 concerning alleged failures by the agency to comply with the requirements of the Act and this part;
5. Obtain a copy of the policy adopted under Section 99.6. A copy of this policy is available by request at the Longview School District Superintendent's Office located at 2715 Lilac Street, Longview, WA 98632

Special Services
2715 Lilac Street
Longview, WA 98632
P (360) 575-7008
F (360) 575-7108

LONGVIEW SCHOOL DISTRICT NO. 122
2715 LILAC STREET, LONGVIEW WA 98632

Submit Form

SPECIAL SERVICES
PHONE: (360) 575-7008
FAX: (360) 575-7108

Authorization for Exchange of Educational Records

Student name_____ Birthdate_____ Age_____ Gender____ Grade ___

Serving school_____ Home school_____ Date _____

I hereby authorize the exchange of records between:

Longview_School_District
Name of agency/person

2715_Lilac_Street
Address

Longview,_WA_98632
City/State/Zip

(360) 575-7008
Telephone

(360)575-7108
Fax

SpecialEducation@longviewschools.org
Email

_____
Name of agency/person

_____
Address

_____
City/State/Zip

_____
Telephone

_____
Fax

Check all record types to be released:

- ☐ Health records
- ☐ Special Education records
- ☐ Evaluations, IEP's, reports & testing
- ☐ Psychological & Counseling records
- ☐ Threat Assessments
- ☐ Other:_____

The reason for exchanging the record(s) information is:

- ☐ Eligibility verification
- ☐ Educational placement
- ☐ Evaluation/Reevaluation eligibility determination
- ☐ New Transfer Student

The Family Educational Rights Privacy Act (FERPA) allows a school district to redisclose educational records to schools in which the student enrolls or intends to enroll. This includes approved nonpublic agencies and other private schools. This information may no longer be protected under federal law.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive services.

I understand that it is my right to request a copy of all information and contest any information I feel is incorrect.

This consent and authorization is valid for 90 days from the date of parent/adult student signature.

Consent may be withdrawn at any time in writing, except where information has already been released based upon my authorization.

_____ _____
Parent/Guardian/Student Signature Date

_____
Relationship

Social/Developmental History Update

Date:_____

Dear Parent/Guardian:

As part of the assessment process, we would appreciate your completion of this form. Please note any changes you have observed in your child over the past three years that should be considered with regard to design of his/her current educational program.

Current address:_____

Phone:_____

HEALTH HISTORY

Child's Name:_____ Birthdate:_____

Brothers/Sisters (age & gender):_____

Family Physician:_____ Phone:_____

Is your child on medications? If yes, what:_____

Health problems and/or restrictions:_____

Past Illnesses:

☐Accidents	☐Operations
☐Ear Infections	☐Serious Head Injury
☐High Fever	☐Serious Illness
☐Seizures	☐Other:_____

Explain any checkmarks:_____

Vision and Hearing: Date last checked:_____ By whom:_____

Have there been consistent problems with: ☐Vision ☐Hearing ☐Speech ☐Motor Development

Please explain:_____

Recent stressors: _____

Family changes that might be significant to the educational process:_____

Parent/Guardian Signature:_____/Relationship_____Date:_____

Child's History:

Complications during pregnancy (explain):_____

_____ High temps._____

Complications at birth (explain):_____

_____ Birth weight:_____

☐Smoked ☐Alcohol Medications:_____

Age at which your child (use "N" if normal): Spoke: words_____ Sentences_____

Sat up_____ Crawled_____ Walked_____ Toilet trained_____

Consistent problems with (mark all that apply):

CONDUCT

☐High activity level
☐Distractible
☐Frequent inter-personal problems
☐Aggressiveness
☐Impulsivity-unable to delay gratification
☐Lying
☐Stealing
☐Difficulty with authority rules, limits, laws

ANXIETY/DEPRESSION

☐Unhappiness/depressed mood
☐Apprehension/worrying
☐Somatic complaints/illnesses
☐General nervousness
☐Food issues
☐Nightmares
☐Sleep problems/increased or decreased
☐Thumb sucking, nail-biting or other nervous habits
☐Bedwetting
☐Concern about physical appearance
☐Unreasonable fears
☐Difficulty with attention/concentration
☐Suicidal ideations

THOUGHT PROCESSES

☐Bizarre ideas
☐Disconnected, loose fragmented language
☐Inability to deal with abstraction, environmental changes
☐Inability to express ideas
☐Unusual social mannerisms/ behaviors

Please explain as needed:_____

_____

Behavioral:

Does your child have trouble getting along with (check if yes):

☐Children at school ☐Other children
☐Brothers and sisters ☐Parents
☐Teachers ☐School

Comments:_____

_____

Special Interests:_____

Does your child have difficulty accepting responsibilities at home? ☐Yes ☐No

Most effective method of discipline:_____

Educational:

Past school experiences (include grades repeated, dates, and location)_____

_____

Please provide any additional comments, concerns or background information that might assist us in working with your child:_____

_____

Student ID:
WA SSID:
Date of Birth:

Longview Public Schools
2715 Lilac
Longview, WA 98632
360-575-7008

Medicaid Consent

Date: _____

PURPOSE: This form asks for your consent to share the necessary information to verify Medicaid eligibility and bill for school-based Medicaid reimbursement with the Department of Social and Health Services, Health and Recovery Services Administration. The district is required to obtain parent consent each time they bill for a new procedure. Billing DSHS does not affect individual benefits under Medicaid or require a co-pay or deductible. If you have questions regarding this request, call the school district's Director of Special Education or designee for an explanation as to why the request is being made.

Student's Name: _____ Student's Number: _____

Current School: _____ Date of Birth: _____

State law requires the school district to submit claims for health-related services provided to special education students or students referred for special education. These services include physical therapy, occupational therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluation.

With your permission, Longview Public Schools will submit your student's name and birth date to the Department of Social and Health Services (DSHS) to verify Medicaid eligibility. Such a request will in no way negatively impact services included in your child's individualized education program (IEP).

With your permission, we will share necessary identifying information from your child's education record to access federal Medicaid reimbursement from the Department of Social and Health Services (DSHS). If any additional Medicaid reimbursement services are added to the IEP, the school district will request additional consent. This consent is good for 365 days. If my child no longer is served by this school district, this consent does not transfer to a new district.

This authorization will begin on _____ and expire on _____.

By giving consent, you are acknowledging that (1) you have been fully informed of all information relevant to the activity for which consent is sought; (2) you understand that the granting of consent is voluntary on your part and may be revoked at any time; and (3) if you revoke consent, the revocation is not retroactive; which means that it does not negate any activity that has already taken place.

☐ I give my consent to verify Medicaid eligibility with DSHS and to submit claims for allowable services.

☐ I do not give my consent to verify Medicaid eligibility with DSHS and to submit claims for allowable services. I understand that my refusal does not affect my child's access to services under the Individualized Education Program.

_____ _____
Signature of Parent Date