DEERFIELD PUBLIC SCHOOLS
DISTRICT 109

Date: _____ **School:** _____

Student's Name: _____ **Birth Date:** _____

Parent's Name: _____ **Phone:** _____

District 109 seeks your permission to collaborate with your private provider or outside agency regarding your child. The purpose of this communication is to be able to assist and program for your child appropriately. In this collaboration, we will be sharing information or seeking to learn information that
relates to:

- ☐ Social Emotional Functioning
- ☐ Behavioral Topics
- ☐ Personal/Familial Information
- ☐ Academic Performance
- ☐ Academic History
- ☐ Medical Information
- ☐ Educational Needs
- ☐ Evaluation Results
- ☐ Other:

The educational relevance is:

_____

_____

I give my permission for District 109 personnel to contact the following individuals regarding my child. This consent is valid until:_____

Name/Agency: _____
Address: _____
Phone Number: _____
Email: _____

_____ _____
Parent/Guardian Signature Date

_____ _____
Student's Signature (Age 12 & over) Date

517 Deerfield Road | Deerfield, Illinois 60015
(847) 945-1844