

PURPOSE: A school district must inform parents/guardians of all information relevant to the district making a decision regarding the initial evaluation, initial placement, or reevaluation of a student. This form asks for your consent to the above mentioned activities. If you have questions regarding this request, you may call the school district director of special education for an explanation as to why the request is being made.

PARENT CONSENT

Date: _____

To: _____
(Parent/student/guardian)

We are requesting your consent for the action checked below regarding your child, _____
(student's name)

Student's Birthdate: _____ ID#: _____ School: _____

The attached written notice explains the action to be taken.

We ask consent to take the following action:	
<input type="checkbox"/>	Initial evaluation of your child.
<input type="checkbox"/>	Initial placement in special education.
<input type="checkbox"/>	Reevaluation of your child.
<input type="checkbox"/>	Other.

Records that will be released (if any) and to whom:

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; (3) if you revoke consent, the revocation is not retroactive; and (4) if you refuse to give consent, the district may request mediation or a due process hearing in order to ensure services to your child. Consent is not required when the district has made reasonable measures to obtain your consent for reevaluation and you have failed to respond.

I give my consent.

I do not give my consent.

Parent/guardian signature

Date

Parent/guardian signature

Date

PRIOR WRITTEN NOTICE MUST ACCOMPANY THIS FORM.

PURPOSE: This form asks for your consent to obtain information from the Department of Social and Health Services, Medical Assistance Administration for the purpose of Medicaid eligibility verification. If you have questions regarding this request, you may call the school district director of special education for an explanation as to why the request is being made.

MEDICAID ELIGIBILITY VERIFICATION

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, we 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).

I do give consent to verify Medicaid eligibility with DSHS.

I do not give consent to verify Medicaid eligibility with DSHS.

Parent/guardian signature

Date