Oak Park Elementary School District 97

970 Madison ▪ Oak Park ▪ Illinois ▪ 60302 ▪ ph: 708.524.3000 ▪ fax: 708.848.8696 ▪ Website: www.op97.org

School/Teacher Referral
Early Childhood Special Education Evaluation

Child's Name:_____

Child's DOB:_____

Parent/Guardian:_____

Phone:_____

Check one referral:
☐ Full Evaluation ☐ Sp/L Evaluation

Referring School:_____

Referring Teacher:_____

Teacher Phone:_____

Describe specific reason/s why you believe an evaluation is needed:

Do parents have concerns? If so, what are their concerns?

List previous actions taken to resolve the situation listed above and attach documentation/ data of interventions/strategies used:

Detail how areas of concern are affecting the student's involvement and progress in the general education curriculum. Please also attach any documentation (test results, etc).

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Parent Referral Form
Early Childhood Special Education Evaluation

Child's Name:_____

Child's DOB:_____

Parent/Guardian:_____

Phone:_____

Check one referral:
☐ Full Evaluation ☐ Sp/L Evaluation

Referring School:_____

Referring Teacher:_____

Teacher Phone:_____

1. What concerns do you have with your child's development in the following areas?

   A. Cognitive/academic:

   B. Speech/language:

   C. Fine/gross motor skills:

   D. Social/emotional skills:

   E. Self help skills:

2. Do you have any concerns about your child's behavior?

3. What actions has the school taken to resolve the situation listed above (i.e. interventions/ strategies used)?

4. Please list some things your child enjoys/or is good at doing at home:

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970 Madison ▪ Oak Park ▪ Illinois ▪ 60302 ▪ ph: 708.524.3030 ▪ fax: 708.848.8986 ▪ Website: www.op97.org

Consent to Release Protected Educational, Mental/Physical Health and Legal Information

Student's Name _____ Date of Birth _____

I authorize and request, the release of the following protected Educational, Mental/Physical and Legal information regarding the student named above:

☐ Individual Educational Plan – IEP	☐ Therapeutic Summaries - OT/PT	☐ Psychiatric Reports
☐ Educational Reports	☐ Progress Reports	☐ Discharge Summaries
☐ Disciplinary Reports	☐ Psychological Evaluations	☐ Medical/Physical Forms
☐ Social Histories	☐ Legal/Court Reports	☐ Hearing/Vision Reports
Other: observations	Other: _____	Other: _____

This information will be released from:

_____

_____

_____

Phone: _____

FAX: _____

This information will be released to:

Oak Park Public Schools District 97
970 W. Madison Street
Oak Park, Il 60302

Phone: (708)524-3030
FAX: (708)848-8986

This information will be released from:

Oak Park Public Schools District 97
970 W. Madison Street
Oak Park, Il 60302

Phone: (708)524-3030
FAX: (708)848-8986

This information will be released to:

_____

_____

_____

Phone: _____

FAX: _____

This authorization expires one year from the date indicated below. It is limited only to the information listed above, which will be released from, and to, only the individuals, agencies and/or schools named above. The purpose of this release of information is to assist in providing continuity of care. I understand I have the right to revoke this authorization at any time by submitting a request in writing. I also understand that I have the right to inspect and copy the information disclosed. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such material to the individual(s) and school(s) named herein, with the consequence of reduced accuracy and quality/completeness of care provided.

Signature of Parent/Guardian: _____ Date: _____

Signature of Student (12 years or older): _____ Date: _____

Witness: _____ Date: _____