

Woodridge Local School District

CONSENT FOR EVALUATION/RECEIPT OF NOTICE OF SECTION 504/ADA PROCEDURAL INFORMATION AND RIGHTS

Date: _____

Name: _____	Date of Birth: _____	Age: _____
Building: _____	Grade: _____	
Parent/Guardian Name(s): _____	Phone: _____	
Address: _____		
City: _____	State: _____	Zip: _____

Your child has been referred for an evaluation to determine eligibility for protection under Section 504 of the Rehabilitation Act of 1973 (as amended) and/or the Americans with Disabilities Act (ADA) (as amended). A copy of the Board of Education's Section 504/ADA Policy and Administrative Guidelines is available to you by contacting your building principal or the _____. A copy of the Notice of Section 504/ADA Procedural Information and Rights is enclosed.

For Office Use Only

Date Sent: _____ Case Manager Initials: _____

The Section 504 evaluation team will consider the following areas:

Your signed consent is required to complete this screening/evaluation. The results will be communicated to you and appropriate school personnel. All results are confidential in accordance with State and Federal laws pertaining to education and/or health records. The school will obtain and review information from a variety of sources in order to make a proper evaluation of your child's condition. The evaluation will be completed within approximately sixty (60) calendar days.

As parent/guardian: I DO consent to this evaluation.*
 I DO NOT consent to this evaluation.

* Consent may be revoked at any time.

Parent/Guardian Signature: _____ Date: _____

For Office Use Only			
Copies to:	___ District 504 Coordinator	___ Building Administrator	___ Teacher(s)
___ Parent(s)	___ Files	___ District Health Coordinator	___ School Counselor

1/16/07
10/19/10