Request to Access Classroom(s) or Personnel for Special Education Evaluation and/or Observation Purposes

Student Name:____Date of Birth:___________________
Current School:_______________________________________Current Grade:___________________

The following information must be completed by individuals requesting access to a school building, facility, and/or educational program or to interview CPS personnel or the student named above for the purpose of assessing the student's special education needs. Please complete this form and return it to the school Principal or Special Education Case Manager where the student is currently enrolled. The Principal, or designee, will contact you to coordinate your visit.

NOTE: *Observations are typically limited to one class period to ensure minimal disruption to the educational process.*

Observation by Parent/Guardian *(Only complete this section if the parent/guardian will be the individual that will be conducting the observation.)*

Name:_______________________________________Relationship to Student:___________________
Phone:(______)____________Address:____

☐ **Current Setting**: I am the parent/guardian of the above named student and wish to observe my child in the following classroom/settings:____
The purpose of my observation is:____
____

☐ **Proposed Setting**: I am the parent/guardian of the above named student and wish to observe the following classroom/settings which have been recommended for my child:________________________________
____

Observation by Parent's Independent Evaluator or Other Qualified Professional *(Complete this section if the person making the request and/or participating in the observation is not the parent/guardian.)*

Name:_________________________________Agency/Company:______________________________
Phone:(______)__________________________Email address:_________________________________
Address:____
My professional training and/or licensure or certification, if applicable, is (check all that apply):

- ☐ Teacher, certified in the areas of:____
- ☐ Clinical Psychologist
- ☐ School Psychologist
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Social Worker
- ☐ School Social Worker
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Speech/Language Pathologist
- ☐ Audiologist
- ☐ Psychiatrist
- ☐ Registered Nurse
- ☐ Certified School Nurse
- ☐ Other qualified professional (list credentials):____

I have been requested by the above named student's parent/guardian to conduct an evaluation of the student for the purpose of:____
____
____

As part of this evaluation, I am requesting the following for the length of time noted (check all that apply):

☐ Observation of student in the following classroom(s)/setting(s):________________________________
____
____
____

Duration:____

Proposed Observation Date:____

☐ I will need more than one class period for my visit for the following reason(s):____________________
____
____

☐ Opportunity to interview the student

NOTE: *The following two options require that the Parent/Guardian complete the Authorization to Release Student Record Information found below or attach a separate signed release of student record information.*

☐ Opportunity to interview the following personnel believed to work with the student:________________
____

Duration:____

Proposed Interview Date:____

☐ Student records

Observation Acknowledgement *(To be completed by the person conducting the observation.)*

I understand that CPS will allow me reasonable access to the above referenced student, his/her educational program or proposed program, the school facilities, and/or the individual(s) I have requested to interview as related to the purpose of my visit. I agree to comply with the school's safety, security, and visitation policies at all times. I further understand that during my visit, I agree that I must honor all students' confidentiality rights and refrain from interviewing any student other than the above referenced student. I also agree to refrain from reviewing any student records other than the above referenced student's records and refrain from any re-disclosure of such records.

____ ____________________

Individual Conducting Observation Signature Date

Parent/Guardian Verification *(Must be completed whenever an independent evaluator or other qualified professional requests access.)*

I, ____, am the parent/guardian of the above named student, and I confirm that I have requested an evaluation of my child by the individual named herein, for the stated purpose(s). If requested above, I consent to my child being interviewed by the named evaluator as part of this visit understanding that CPS has not conducted a background check on the evaluator. I have no reason to believe the evaluator poses a safety risk to my child or others. I further understand and agree that it is my responsibility to notify CPS in writing if I end my working relationship with the named evaluator prior to the completion of the tasks outlined herein and that CPS otherwise will work with the evaluator to provide reasonable access to the school facility, personnel and/or my child at mutually agreed upon times and in a manner that is least disruptive to the school setting or my child's academic program. I agree that a photocopy, facsimile or digital copy of this form will carry the same legal force and effect as the original.

____ ____________________

Parent/Guardian Signature Date

Parent/Guardian Authorization to Release Student Record Information *(Must be completed whenever an independent evaluator or other qualified professional requests access to student records or to interview CPS personnel.)*

My signature below grants permission to the Chicago Public Schools, and the evaluator or other qualified professional indicated above, to freely exchange personally identifiable oral and/or written school information regarding the above-named student. This information is intended for use in educational decision making. I acknowledge refusal to sign will result in the information not being released. I agree that a photocopy, facsimile or digital copy of this form will carry the same legal force and effect as the original. I further acknowledge that I understand I have the right to revoke this consent in writing at any time, and to inspect, copy or challenge the contents of the records being requested prior to release. Knowing this, I agree to authorize the release of the designated records pursuant to 105 ILCS 10/6(a)(8) of the Illinois School Student Records Act (ISSRA). This consent covers the full contents of the temporary and permanent education records as these are defined in ISSRA. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I understand that if the above referenced student is over the age of 12 and the records contain mental health and/or developmental disability information, the student must also sign the Authorization to Release Student Record Information before any disclosure of school student records or information to an evaluator or other qualified professional. This authorization is valid for one calendar year from the date of signature below.

____ ____________________

Parent/Guardian Signature Date

____ ____________________

Student Signature* (Only if over 12 years old) Date

* The student’s signature is required if the minor student is over the age of 12 and the student records subject to this authorization contain mental health records.