

**Observations and Evaluations of Students with Disabilities**

**8:32-E Exhibit - Request to Access Classroom(s) or Personnel for Special Education Evaluation and/or Observation Purposes**

Student name:DOB:

School attending:Grade:

The following information must be completed by individuals requesting to access a school building, facility, and/or educational programs or to interview P.A.E.C. 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 Principal or Executive Director. He or she will contact you to coordinate your visit:

**Parent/Guardian** *(Complete this section if the person making the request is the parent/guardian.)*

Name: \_\_\_\_\_ Title: Phone: \_\_\_\_\_

Address: \_\_\_\_\_

I am the parent/guardian of the above-named student and wish to observe my child in the following classroom/settings:

for the purpose of:

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:

\_\_\_\_\_  
\_\_\_\_\_

for the purpose of:

\_\_\_\_\_

*Observations are limited to one (1) hour or one (1) class period per school quarter.*

**Independent Educational Evaluator or Qualified Professional on Behalf of the Parent/Guardian** *(Complete this section if the person making the request 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: Illinois certified?  Y  N

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
- Assistive Technology Specialist
- 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:

*Evaluations are limited to three (3) hours per school year, unless a longer duration of time is necessary as determined by the student's IEP team.*

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: \_\_\_\_\_

- Opportunity to interview the following personnel believed to work with the student or who work in a program proposed for the student by the IEP team:

<b><u>Staff Person Name/Position</u></b>	<b>I</b>

- Opportunity to interview the student. Duration:

- I am requesting more than one hour or one class period for my evaluation for the following reason(s):

Student records, as noted in the attached, signed Authorization to Release Student Record Information.

**Acknowledgement** *(To be completed by the person making the access request.)*

I understand that P.A.E.C. will allow me reasonable access to the school, school facilities, or educational programs or individual(s) I have requested as related to the purpose of my visit. I have been provided with a copy of 6:120-AP2, *Access to Classrooms and Personnel*, and agree to comply with its terms and conditions. I further understand that during my visit, I must honor all students' confidentiality rights and refrain from any re-disclosure of any information regarding other students that is obtained during my visit.

\_\_\_\_\_  
Individual Requesting Access Signature      Date

**Parent/Guardian Verification** *(Must be completed whenever an independent evaluator or other qualified professional on behalf of the parent/guardian 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 observed and interviewed by the named evaluator as part of this evaluation understanding that P.A.E.C. 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 P.A.E.C. in writing if I end my working relationship with the named evaluator prior to the completion of the tasks outlined herein and that P.A.E.C. otherwise will work with the evaluator to provide reasonable access to the school, school building, school facility, personnel, 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.

\_\_\_\_\_  
Parent/Guardian Signature      Date

ADOPTED: October 11, 2011

**Proviso Area for Exceptional Children (P.A.E.C.)**

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