

**SECTION 504
CONSENT FOR ASSESSMENT**

Date _____

To the Parent(s)/Guardian(s) of _____ Birth date _____

District/School _____ Language of Home _____ Language of Pupil _____

The purpose of this assessment is to determine whether or not your child has a disability within the meaning of Section 504 of the Federal Rehabilitation Act of 1973. According to Federal regulations, a disabled student is any student "who has a physical or mental impairment that substantially limits one or more major life activities, who has a record of such impairment, or who is regarded as having such an impairment." Major life activities include: caring for one's self, seeing, walking, lifting, speaking, hearing, bending, breathing, standing, working, performing manual task, sleeping, eating, reading, learning, concentrating, thinking, and communicating.

Assessment in the areas indicated below will be conducted by appropriately qualified staff, and when appropriate, use a suitable interpreter in the student's primary language. The assessment may include observation of the student in an appropriate setting, interview with the child's parents, legal guardian or person who holds educational rights, plus a review of any reports that have been authorized or that already exist in current school records.

Areas of Proposed Assessment:

- _____ Academic/Pre-Academic Achievement
- _____ Social/Adaptive Behavior
- _____ Perceptual Motor Development
- _____ Communication Development
- _____ Intellectual Development
- _____ Other

Other Areas of Assessment:

_____ Family History _____ Health/Developmental History _____ Vision _____ Hearing _____ Other

The following professionals/code designation will have primary responsibility for conducting the assessment as outlined above: (1) Nurse, (2) Psychologist, (3) Speech and Language Pathologist, (4) Teacher, (5) other: _____

If you have any questions about the proposed assessment, please call the following person before signing:

Name _____
Phone _____

I hereby give my permission for the assessment indicated above to be completed. I understand that the results will be kept confidential. I also understand that I will be invited to a meeting to discuss the results of this assessment. I have reviewed and understand the Due Process Procedures and Parental Rights to Section 504 provided to me.

Signature of Parent/Guardian _____ Date _____

Signature of Interpreter (if necessary) _____ Date _____