Radford City Public Schools
1612 Wadsworth Street
Radford, VA 24141
540-731-3647

Student ID:
FTE Number:
Student Testing ID:
Date of Birth:

Meeting Notice

To: ______________________ Letter Dates: __________ __________

Student's Name: ______________________ Date Sent To Participants: __________

This is to notify you that a team meeting has been scheduled for the above student. Your participation and attendance at this meeting are very important. The purpose of this meeting is to:

This meeting has been scheduled for: Date ________ Time ________ Location ______________

The following are invited to attend and participate in the meeting:

______________________ ______________________

______________________ ______________________

The parent/adult student or school division may invite individuals who have knowledge or special expertise regarding the student, including related services personnel, to participate. The determination of the knowledge or special expertise shall be made by the person/party extending the invitation. If you, the parent or adult student, are bringing other individuals to the meeting, please let us know. This will ensure that the meeting space will accommodate all team members.

If you have any questions or would like additional information or assistance to help you prepare for this meeting, please contact
______________________ at ______________________
email ______________________.

To the Parent/Student

Student: ______________________ Date of Meeting: __________

Please check your choice. Detach and return this section to ______________________ Fax: __________

_______ I, the parent, _______ I, the student, **will attend** the meeting as scheduled.

_______ I, the parent, _______ I, the student, **cannot attend** the meeting as scheduled. Please consider rescheduling this meeting.

_______ I, the parent, _______ I, the student, **do not wish to attend** this meeting even though I understand the importance of attending. You may hold this meeting in my absence.

_______ I, the parent, _______ I, the student, would like my preferences, interests, and concerns shared with the team.

_______ I will provide my input to you by:_____ mail, _____ telephone, _____ or other means:______________ prior to the meeting.

I will need the following accommodations for this meeting:

Parent Signature ______________________ Date ______________ Date received by the school ______________

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Meeting Minutes

Student's Name: ______________________________ Student No: ____________
First *Middle* *Last*

Date of Referral: __________ Race: ____________________

Parent Notification:

☐ Telephone Date __________ By Whom ____________________

☐ Letter Date(s) ______________ ☐ Conference Date __________

Contact Name ______________________________ Work Phone ____________

Contact Name ______________________________ Work Phone ____________

Home Address ______________________________ Home Phone ____________

Date of Birth __________ School ______________________ Grade ____________

*Family Doctor or Pediatrician ______________________________

*Clinic Affiliation ______________________________

Child Study Committee Meeting Date: __________

Referring Source ____________________ Relationship ____________________

I. Reason for request (attach copy of the interim reports and current report card)

II. Summary of Strategies used to date and the effectiveness of strategies on student's achievement and/or adjustment
(include input from parents and those persons who have worked with the student)

III. Present instruction levels:
Reading:

Math:

Written Language:

Strengths:

Needs:

IV. Minutes

V. Goals and Strategies

Date	Area Specific Goals and Strategies	Method of Evaluation	Personnel Responsible

VI. Recommendation ______________________________

VII. Individual responsible for parent notification (if not present at meeting) ____________________

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Meeting Minutes

VIII. Individual designated to inform referring source (if not present at meeting) ______________________

IX. Projected Date of Review ____________ Case Manager ______________________

Child Study Committee Members

______________________	Date	______________________	Date
______________________	Date	______________________	Date

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Medical Permission

Student: ______________________ Date of Birth: ______________

School: ______________________

Dear Parents:

Medical Examinations are required for some of the students being evaluated to determine eligibility for special education or Section 504 determination.

If your child has a significant medical history, please utilize the Release/ Exchange of Confidential Information form to enable your physician to communicate and share records with our agency.

If your child has HAD a physical within the past twelve (12) months, this may be used as the medical component. Please complete Part I of the Health Information Form (MCH-213-D) and have your physician complete Part II of this form or send a copy of the complete physical to your child's school.

Sincerely,

____
Principal or Designee

If your child requires a new physical, you may have your child examined by your own physician at your expense or by a Radford City Public Schools physician at no expense to you. Please check the option you prefer, sign and date.

☐ I prefer to have my own physician examine my child at my own expense.

☐ I hereby give permission to Radford City Public Schools to provide a complete medical examination for my child at no expense to me. I understand that I am responsible to schedule my appointment and transportation and transport my child to the physician.

______________________ ______________
Parent / Guardian / Surrogate Date

Return to Clinic Attendant/School Nurse at your child's school as soon as possible

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Student ID:
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Prior Notice

Student's Name: ______________________________

Student's Number: ______________________________

Date of Birth: ______________________________

Dear Parent(s):

Radford City Public Schools (VA) is required to provide written notice to parents when the schools propose or refuse to initiate a change in the identification, evaluation, or educational placement for the provision of a free appropriate public education (FAPE) for your child.

The following meeting was held regarding your child:

Date of Meeting: ____________________

Nature of Meeting:

[ ] Child Study
[ ] Eligibility
[ ] Plan

1. Actions proposed or refused by Radford City Public Schools:

2. Rationale for why actions were proposed or refused:

3. Other options considered:

4. Reason other options were rejected:

5. Description of any assessment data or reports used to make the decision:

6. Other factors relevant to proposal or refusal:

7. Follow-up meeting date, if appropriate: ______________

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Prior Notice

You have protection under procedural safeguards. A copy of your parental rights is enclosed with this notice. To obtain assistance in understanding the provisions of this part of your rights, you may contact either your child's case manager or the Special Education at 540-731-3647.

____
Principal/Designee Signature

I have received a copy of my parental rights. ☐ Yes ☐ No ______________________________
Parent/Guardian Signature

CC: Student file, Case Manager

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Parental Consent to Evaluate

Date Sent: ____________________

Student's Name: ____ Student No: ____________________
First *Middle* *Last*

Birth Date: ______________ Sex: ____________ School: ______________________________ Grade: ____________

I understand that parental consent is not required before reviewing existing data as part of an evaluation or administering a test or other evaluation that is administered to all children, unless parental consent is required before administration to all children. Parental consent for initial evaluation shall not be construed as consent for initial provision of special education and related services. (34 CFR 300.300)

I understand that a variety of assessment tools and strategies will be used to gather relevant functional, developmental, and academic information about my child.

Areas of Evaluation:

- ☐ Educational
- ☐ Audiological
- ☐ Speech and Language
- ☐ Sociocultural
- ☐ Occupational Therapy
- ☐ Observation
- ☐ Physical Examination
- ☐ Functional Behavioral Assessment
- ☐ Other
- ☐ Developmental
- ☐ Medical
- ☐ Vision
- ☐ Hearing Screening
- ☐ Psychological
- ☐ Physical Therapy
- ☐ Assistive Technology
- ☐ Current Class Performance
- ☐

I consent for ______________________________ (Local Education Agency) to conduct or administer the evaluation components listed above. The results of these evaluations will be used to determine:

1. whether my child is or continues to be a child with a disability
2. my child's educational needs
3. the other matters set forth on the attached Review of Existing Data Summary

I understand that the evaluation reports will be available to me two business days prior to the eligibility meeting. I understand that the evaluation will be completed at no cost to me and a written copy of the evaluation report(s) shall be provided to me, at no cost, prior to or at the meeting where the eligibility group reviews the evaluation report(s) or immediately following the meeting, but no later than ten days after the meeting.

Procedural Safeguards: I understand my right to withhold consent for the school division to evaluate my child. I understand that my permission is voluntary and may be revoked at anytime.

- ☐ I give consent for the evaluation.
- ☐ I do not give consent for the evaluation.

____ ____________________
Parent Signature Date