**SOUTH BEND COMMUNITY SCHOOL CORPORATION**
**SPECIAL EDUCATION DEPARTMENT**

# RECORD OF PARENTAL REQUEST FOR RE-EVALUATION

Student's name: _____ DOB: _____
School: _____ Grade: _____ Teacher: _____
ID# _____ STN#: _____
Parent's name: _____
Address: _____
_____

**Certified Personnel*** who received Request for Evaluation: _____
How Request was received: _____
**Date of Request:** _____

**PARENT**

*If the parent makes the Request for an evaluation in person at the school, please have the parent sign below.*

I am requesting a re-evaluation for my child, _____, DOB: _____.
Place your initials on the appropriate option below:

_____ *I suspect that my child may have a different or additional eligibility for special education services. I suspect the disability(ies) of: _____.

_____ *Additional information is needed to inform the Case Conference Committee of my child's special education needs. Describe specifically: _____
_____

_____ There is a need to re-establish my child's eligibility to determine if he/she continues to be eligible for special education services. I understand that my child will be re-evaluated prior to the next Annual Case Conference.

*I understand that within 10 school days, I will receive Written Notice informing me whether the school proposes or refuses to evaluate my child. At that time, if the school makes a recommendation to proceed with the evaluation, I will be asked to provide written consent for this evaluation.

Parent Signature: _____ Date: _____

……

*If the parent does not make the Request in person at the school, the certified personnel who received the Request must document at the top of this page, his/her name, the date of the request, and the type of re-evaluation requested. It is not necessary to have the parent sign this form.*

**THIS COMPLETED FORM MUST BE <u>IMMEDIATELY</u> FORWARDED TO THE TEACHER OF RECORD who will distribute the Classroom Teacher Report and distribute copies of this page to those on the CC list.**

Date distributed to Teacher: _____

**CLASSROOM TEACHER**

The parent of the above named student has requested a re-evaluation.

The attached *CLASSROOM TEACHER REPORT* **MUST** be completed and returned it to the school psychologist within **3 school days** (due _____). This information will be used by the psychologist to assist in determining if the school will conduct the evaluation. The parent must be informed of this decision within 10 school days of the Request.

* = principal, guidance counselor, teacher, psychologist, speech/language pathologist

Cc: Teacher
Cum
Psychologist/Sp.Ed. file
Principal
Parent