



## Parent Permission for Evaluation - Referral

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Date: \_\_\_\_\_

Dear parents:

In order to provide the best services for your child, we would like to schedule further testing in the areas marked below or a referral:

_____ Educational	_____ Language	_____ Medical
_____ Psychological	_____ Speech	_____ Referral to LEA/CFC
_____ Adaptive Behavior	_____ Physical Therapy	(Local Educational Agency//Child and Family Connections)
_____ Social History	_____ Occupational Therapy	_____ Other

With this permission, your child will be referred to:

\_\_\_\_\_ (name of diagnostician or LEA/CFC)

Please indicate with your signature below whether you wish us to proceed with the evaluation understanding that we must refer to CFC within 2 days, and if you would like to participate in the process.

I received the educational rights of students with disabilities booklet in my primary language and its content was explained to me. (Parent Initial) \_\_\_\_\_

I would like to participate in my child's evaluation. (Parent initial) \_\_\_\_\_

I **CAN - CAN NOT** give permission for the above stated evaluation of my child and for the exchange of information regarding that evaluation between the program and the named diagnostician or agency.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

If you need any accommodation to better understand this, please ask for it.