TRI-COUNTY SPECIAL EDUCATION JOINT AGREEMENT
Jan Pearcy, Director
1725 Shomaker Drive, Murphysboro, IL 62966
Phone: (618) 684-2109 FAX: (618) 687-1638

REQUEST FOR CONFIDENTIAL INFORMATION

Name of Student:______________________________Birthdate:_________Sex:________Grade: ______

Address: ____
Street, Apt. No. City State Zip

____

As parent or legal guardian of the above named student, I grant my permission to:

Check only one: ( ) Release to: ( ) Obtain From: ( ) Exchange With:

Name of Agency/School: ____

Address: ____

Phone: ____

I understand my permission covers the release of permanent and temporary records, as well as the release of confidential records and reports. This may include one or all of the items listed below. Please forward the school records as indicated.

( ) Academic transcripts
( ) Teacher anecdotal information
( ) Psychological evaluations
( ) Conference Summary Reports
( ) Social Developmental Report
( ) Assessment of Cultural Background
( ) Health Assessment
( ) Related Services report
( ) Disciplinary information
( ) Verified reports & evaluations from non-school persons or agencies
( ) Adaptive Behavior Assessment
( ) Medical records
( ) Vision & Hearing screenings
( ) Other (please specify)

I also understand I have the right to inspect and copy school records. I further understand this authorization shall expire without any revocation on:___________, 20___.

______________________________________ ____________________
Signature of Parent/Guardian or Adult Student Over Age Date

______________________________________ ____________________
Signature of Child Age 12 and Over (if applicable) Date

______________________________________ ____________________
Witness Signature Date

Please return this form to the TCSE Records Custodian at your earliest convenience. Parent and Student Request for Records will be processed within 10 business days of receipt of this Request Form.