

TRI-COUNTY SPECIAL EDUCATION JOINT AGREEMENT

Jan Percy, Director

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Phone: (618) 684-2109 FAX: (618) 708-3403

REQUEST FOR CONFIDENTIAL INFORMATION

MUST BE SUBMITTED TO RECORDS CUSTODIAN

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

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 18

Date

Signature of Child Age 12 and Over (if applicable)

Date

Witness Signature

Date