Student ID:
FTE Number:
Date of Birth:

Spotsylvania County Public Schools
8020 River Stone Drive
Fredericksburg, VA 22407
540-834-2500

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. This meeting must be scheduled at a mutually agreed upon time and place. The purpose of this meeting is to conduct a screening of information related to your child's educational needs.

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 reschedule this meeting.
I can attend on(month/ day/ year) ______________ at (time/place) ______________________
Please contact me at ______________ to determine a mutually agreeable date, time, and place for 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*

Social Security No: ____________ 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 ______________________ ____________

*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. Referral ______________________________

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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Student ID:
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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 Spotsylvania County 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 Spotsylvania County Public Schools to provide a complete medical examination for my child at no expense to me.

______________________________ ______________
Parent / Guardian / Surrogate Date

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

Student ID:
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Prior Notice

Student's Name: ____________________

Student's Number: ____________________

Date of Birth: ____________________

Dear Parent(s):

Spotsylvania County 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. Options or actions proposed by Spotsylvania County Public Schools:

2. Rationale for why options were proposed:

3. Other options considered:

4. Reason other options were rejected by the division:

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

6. Actions taken:

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

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Student ID:
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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 Spotsylvania County Special Services at 540-834-2500.

____
Principal/Designee Signature

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

CC: Student file, Case Manager

Spotsylvania County Public Schools
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Student ID:
FTE Number:
Date of Birth:

Consent for Evaluation

Date Sent: ____________

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

Birth Date: ________ Sex: ________ School: ______________ Grade: ________

I hereby give consent for Spotsylvania County Public Schools to complete the following components, as indicated, to assess my child in all areas:

- ☐ Educational
- ☐ Audiological
- ☐ Speech and Language
- ☐ Sociocultural
- ☐ Occupational Therapy
- ☐ Observation
- ☐ Physical Examination
- ☐ Other
- ☐ Developmental
- ☐ Medical
- ☐ Vision
- ☐ Hearing Screening
- ☐ Psychological
- ☐ Physical Therapy
- ☐ Assistive Technology
- ☐

I understand that I have the opportunity to participate in the consideration of the areas to be assessed. I would suggest the following areas of need be considered in assessing my child:

I also have been given the statements prepared by the Spotsylvania County Special Services that summarize protections for students who may require special education.

☐ These evaluations have been explained and I have been informed of my due process rights in language understandable to me. I give consent for my child to be evaluated.

______________________ ____________
Parent/Guardian/Surrogate Date

Please return this form to: ______________________ at ______________________

☐ I refuse consent for my child to be evaluated.

______________________ ____________
Parent/Guardian/Surrogate Date

Comments:

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Procedural Safeguards

Student's Name: ______________________________

Student's Number: ______________________________

Date of Birth: ______________________________

Dear Parent(s),

Spotsylvania County Public Schools offers many special education programs and related services. In order to determine whether your child is eligible for these services, a formal evaluation is needed. The purpose of this evaluation, if it is recommended, is to provide information which will allow us to better meet your child's educational needs. All components of the evaluation are available at no cost to you, the parent. You have the opportunity to participate in the consideration of the areas to be assessed. If recommended, with your consent, we will complete the following evaluations, which are needed in determining your child's need for special education services. You also have the right to appeal our decision to refuse an evaluation:

- ☐ Educational: Written report describing current educational performance and identifying instructional strengths and weaknesses in academic skills and language performance.
- ☐ Developmental: Written report of assessment describing how the child functions in the major areas of development such as cognition, motor, social/adaptive behavior, perception, and communication.
- ☐ Audiological: Written report describing your child's hearing acuity.
- ☐ Medical: Written report from a physician indicating general medical history and any medical/health problems which may impede learning.
- ☐ Speech and Language: Written report describing how well your child can speak and understand language.
- ☐ Vision: Written report describing your child's functional vision skills.
- ☐ Sociocultural: Written report from a school social worker based on interview(s) and social appraisal instruments which describes family history, structure and dynamics; developmental and health history; and social/adaptive behavior in home, school, and community.
- ☐ Hearing Screening: Written report describing the child's range of hearing. [Required during the eligibility process for a child with a disability prior to placement in a special education program.]
- ☐ Occupational therapy evaluation: Written report describing your child's functional fine motor skills.
- ☐ Psychological: Written report from a school psychologist based on the use of a battery of appropriate instruments which may include individual intelligence test(s), psychoeducational tests, measures of perception, and tests of personality and/or behavior.
- ☐ Observation: Written report describing your child's interaction in an educational environment and/or community, as appropriate. [Required if student is suspected of having a learning disability.]
- ☐ Physical Therapy evaluation: Written report describing your child's functional gross motor skills.
- ☐ Physical Examination
- ☐ Assistive Technology
- ☐ Other Recommended Evaluations

The decision to __________________ an evaluation of your child was based on the following:

Before we decided to __________________ an evaluation, the school division considered and/or attempted the following options:

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Procedural Safeguards

These options were rejected because:

In order to perform or obtain the evaluations, your written consent is required. Enclosed with this letter is a copy of your rights as a parent of a child who may require special education services. To obtain assistance in understanding the provisions of this part of your rights, you may contact either ___________________________________ at _______________ or ___________________________________ at _______________.

______________________________ _______________
Child Study Committee Chairperson Date