

CONSENT OF PARENT / GUARDIAN FOR RELEASE OF INFORMATION

For the purpose of ensuring your child is provided with a Free Appropriate Public Education (FAPE), I do hereby give permission for a mutual exchange of information and records concerning:

NAME OF STUDENT: _____ DATE: _____

SCHOOL WHERE ENROLLED: _____ GRADE: _____

Between Michigan City Area Schools and the following:

(Hospital, Clinic, Physician, Institution, Association, or School)

Name of Contact Person: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Fax: _____

Release ALL information

Release the checked information: (Check all that apply)

General Identifying Data (Name, Address, Birth Date, Grade Level Completed, Grades, Class Standing, Attendance Record)

Educational Records

Standardized Achievement and Aptitude Test Scores

Individualized Education Programs (IEP)

Speech / Language Reports

Physical / Occupational Therapy Reports

Psychological / Psychiatric / Educational Evaluation Reports

Medical / Health Reports

Psychiatric Records

Other, Specify: _____

Please Return to:

MCAS, Office of Special Education

408 S Carroll Ave, Michigan City IN 46360

FAX: (219) 877-3548

Attention: _____

SEE REVERSE SIDE FOR CONSENT OF PARENT/GUARDIAN FOR RELEASE OF INFORMATION

