



**SCHOOL ASSOCIATION FOR SPECIAL EDUCATION IN DUPAGE**

**Request to Access SASED Classroom(s) or Personnel for Special Education Evaluation and/or Observation Purposes**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
SASED(DuPage West Cook) Program: \_\_\_\_\_  
Grade: \_\_\_\_\_ District of Residence: \_\_\_\_\_

The following information must be completed by individuals requesting to access a SASED classroom, school building, facility, and/or educational programs or to observe or interview SASED-personnel or the student named above for the purpose of assessing the student’s special education needs. Please complete this form and return it to the SASED Program Administrator. He or she will contact you to coordinate your visit:

**Parent/Guardian** *(Complete this section if the person making the request is the parent/guardian.)*

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

- I am the parent/guardian of the above named student and wish to observe my child in the following classroom/settings: \_\_\_\_\_  
for the purpose of: \_\_\_\_\_
- I am the parent/guardian of the above named student and wish to observe the following classroom/settings which have been recommended for my child: \_\_\_\_\_  
\_\_\_\_\_ for the purpose of: \_\_\_\_\_

*Observations are limited to one hour or one class period per school quarter.*

**Parent’s Independent Evaluator or Other Qualified Professional** *(Complete this section if the person making the request is not the parent/guardian.)*

Name: \_\_\_\_\_ Agency/Company: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email address: \_\_\_\_\_  
Address: \_\_\_\_\_

My professional training and/or licensure or certification, if applicable, is (check all that apply):

- Teacher, certified in the areas of: \_\_\_\_\_ Illinois certified?  Y  N
- Clinical Psychologist
- Licensed Clinical Social Worker
- School Social Worker
- Physical Therapist
- Audiologist
- Registered Nurse
- Other qualified professional (list credentials): \_\_\_\_\_
- School Psychologist
- Licensed Social Worker
- Occupational Therapist
- Speech/Language Pathologist
- Psychiatrist
- Certified School Nurse

I have been requested by the above named student’s parent/guardian to conduct an evaluation of the student for the purpose of: \_\_\_\_\_

As part of this evaluation, I am requesting the following for the length of time noted (check all that apply):

- Observation of student in the following classroom(s)/setting(s): \_\_\_\_\_  
\_\_\_\_\_ Duration: \_\_\_\_\_
- Opportunity to interview the following personnel believed to work with the student: \_\_\_\_\_  
\_\_\_\_\_ Duration: \_\_\_\_\_
- Opportunity to interview the student.
- I will need more than one hour or one class period for my visit for the following reason(s): \_\_\_\_\_  
\_\_\_\_\_
- Student records, as noted in the attached, signed Authorization to Release Student Record Information.

**Acknowledgement** *(To be completed by the person making the access request.)*

I understand that the SASSED will allow me reasonable access to the classrooms, school, school facilities, or educational programs or individual(s) I have requested as related to the purpose of my visit. I have been provided with a copy of 6:120-AP2, *Access to Classrooms and Personnel*, and agree to comply with its terms and conditions. I further understand that during my visit, I agree that I must honor all students' confidentiality rights and refrain from any re-disclosure of such records.

\_\_\_\_\_  
Individual Requesting Access Signature

\_\_\_\_\_  
Date

**Parent/Guardian Verification** *(Must be completed whenever an independent evaluator or other qualified professional requests access.)*

I, \_\_\_\_\_, am the parent/guardian of the above named student, and I confirm that I have requested an evaluation of my child by the individual named herein, for the stated purpose(s). If requested above, I consent to my child being interviewed by the named evaluator as part of this visit understanding that the District has not conducted a background check on the evaluator. I have no reason to believe the evaluator poses a safety risk to my child or others. I further understand and agree that it is my responsibility to notify the School District in writing if I end my working relationship with the named evaluator prior to the completion of the tasks outlined herein and that the School District otherwise will work with the evaluator to provide reasonable access to the school, school building, school facility, personnel or my child at mutually agreed upon times and in a manner that is least disruptive to the school setting or my child's academic program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date