Instruction

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

Student name:______________________________ DOB:____________________

School attending:____________________________ Grade:____________________

The following information must be completed by individuals requesting to access a school building, facility, and/or educational programs or to interview District personnel or the student named above for the purpose of assessing the student's special education needs, or to observe a regular education classroom. Please complete this form and return it to the Building Principal or Program Director where the student is enrolled. 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 ☐ School Psychologist

☐ Licensed Clinical Social Worker ☐ Licensed Social Worker

☐ School Social Worker ☐ Occupational Therapist

☐ Physical Therapist ☐ Speech/Language Pathologist

☐ Audiologist ☐ Psychiatrist

☐ Registered Nurse ☐ Certified School Nurse

☐ Other qualified professional (list credentials):______________________________

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 School District will allow me reasonable access to the 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 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

Classroom Observation Confidentiality Acknowledgment Form

I ______________________________________ have requested to observe a classroom/program in which some students may have educational disabilities. In exchange for permission to observe such a classroom or program, I agree to abide by the following conditions and/or restrictions:

1. My observation must be scheduled in advance with the classroom teacher and will be limited to one class period or 40 minutes, whichever is longer.
2. During the classroom observation, I will not address the teacher or staff present or interact with the students so as not to disrupt the educational process.
3. During the observation, I will remain in the location directed by the teacher so as not to disrupt the educational process.
4. I will not ask questions pertaining to the students in the classroom/program related to their disability, program or services.
5. I will not seek to study or look at work samples from the students in the class or program. This does not prohibit me from requesting documents related to my child outside of the observation.
6. I acknowledge that I cannot access IEPs, student records or any school student record information of students who are not my child before, during or after my observation.
7. I agree that I will not discuss my observation, including a description of the students observed and/or their educational needs, except in the context of an IEP or other educational meeting with school staff related to my child.
8. I acknowledge that school student record information, including all information related to student's disability and individualized education program is highly confidential information protected by the *Family Educational Rights and Privacy Act* and the *Illinois School Student Records Act*, that I have no right to access such information for students who are not my child and, to the extent that I glean information related to another student's disability, educational needs and/or educational program during the observation, I must maintain it in strict confidence.
9. I acknowledge that I cannot disclose any student identifying information to others related to the observation (i.e. the names of the students in a classroom or program; their educational needs or performance as demonstrated during the observation).
10. I will not video or audio record students in the classroom using any device such as, but not limited to, a smartphone, Iphone, Ipad, Ipod or any other electronic means of video or audio recording students or staff.

____

Signature of Observer

____

Date

Classroom Observation Approved By:

____