

LUNENBURG COUNTY PUBLIC SCHOOLS  
SPECIAL EDUCATION DEPARTMENT  
Lunenburg School Board Office  
Kenbridge, VA 23944

**504 MONITORING RECORD**

Name: \_\_\_\_\_ Testing ID#: \_\_\_\_\_  
Last First Middle (10 digit number)

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F Race: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Disability: \_\_\_\_\_ Secondary Disability: \_\_\_\_\_ Tertiary Disability \_\_\_\_\_  N/A

School:  CHS  VES  LMS  KES  N/A Grade Placement: \_\_\_\_\_  N/A

Parent/Guardian: \_\_\_\_\_ Telephone: (H) \_\_\_\_\_  
Address: \_\_\_\_\_ (W) \_\_\_\_\_  
\_\_\_\_\_ (C) \_\_\_\_\_

Referral Reason(s):  Developmental Delay  Academic  Behavior  Speech  Other

Referral Sources(s):  Teacher  Parent  Other \_\_\_\_\_

Type of Referral:  Initial  Reevaluation  Transfer  Triennial Review  DD Review

Prior Notice and Date of Parent/ Guardian/  
Procedural safeguards sent/given to parent: \_\_\_\_/\_\_\_\_/\_\_\_\_ Surrogate Consent: \_\_\_\_/\_\_\_\_/\_\_\_\_

Case manager Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Principal/Designee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

	<u>Date Assigned</u>	<u>Date Received</u>	<u>Date Completed</u>	<u>Comments</u>
<input type="checkbox"/> Educational _____	_____	_____	_____	_____
<input type="checkbox"/> Classroom Observation _____ (New LD)	_____	_____	_____	_____
<input type="checkbox"/> Classroom Performance _____	_____	_____	_____	_____
<input type="checkbox"/> Developmental _____	_____	_____	_____	_____
<input type="checkbox"/> Sociocultural _____	_____	_____	_____	_____
<input type="checkbox"/> Psychological/Psychoeducational _____	_____	_____	_____	_____
<input type="checkbox"/> Behavior Rating Scale	_____	_____	_____	_____
<input type="checkbox"/> Functional Behavior Assessment	_____	_____	_____	_____
<input type="checkbox"/> Medical _____	_____	_____	_____	_____
<input type="checkbox"/> Records _____	_____	_____	_____	_____
<input type="checkbox"/> Physical _____	_____	_____	_____	_____
<input type="checkbox"/> Hearing/Vision _____ (Audiological – if failed twice)	_____	_____	_____	_____
<input type="checkbox"/> Functional Vision Assessment _____	_____	_____	_____	_____
<input type="checkbox"/> Speech/Language _____	_____	_____	_____	_____
<input type="checkbox"/> OT / PT _____	_____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____	_____

Letter to Determine Eligibility Sent: \_\_\_\_/\_\_\_\_/\_\_\_\_ Scheduled Meeting to Determine Eligibility: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Letter to Determine Eligibility Sent: \_\_\_\_/\_\_\_\_/\_\_\_\_ Rescheduled Meeting to Determine Eligibility: \_\_\_\_/\_\_\_\_/\_\_\_\_

Triennial Review Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ DAY 65: \_\_\_\_/\_\_\_\_/\_\_\_\_ DD Review Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Meeting to Determine Eligibility Held On: \_\_\_\_/\_\_\_\_/\_\_\_\_  
[ ] Yes, Eligible [ ] No, Not Eligible If Yes, SPED ID/Related Services: \_\_\_\_\_  
[ ] Recommends further evaluation(s) to include \_\_\_\_\_ and to reconvene following receipt of assessment.  
If applicable, date of withdrawal: \_\_\_\_/\_\_\_\_/\_\_\_\_ If applicable, DATE OF IEP: \_\_\_\_/\_\_\_\_/\_\_\_\_

Completed form should be placed on top of all evaluation requests

**LUNENBURG COUNTY PUBLIC SCHOOLS  
SPECIAL EDUCATION SERVICES - MEETING NOTICE  
Parent Notice**

To: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Date Sent to Participants: \_\_\_\_\_

This is to notify you that a team meeting has been scheduled for the above named 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:

- Determine the need for an initial evaluation for special education and related services
- Determine the needed evaluation component(s) for an initial evaluation for special education and related services
- Determine the need for a re-evaluation for special education and related services
- Determine the needed evaluation components(s) for a re-evaluation for special education and related services
- Determine initial eligibility for special education and related services\*
- Determine continued eligibility for special education and related services\*

- Consider changing the student's identified disability
- Conduct a manifestation determination review prior to a change in placement i.e. a long term suspension or expulsion and including removal to an interim alternative educational setting
- Develop a Functional Behavioral Assessment plan
- Develop a Behavioral Intervention Plan
- Review and/or revise a Behavioral Intervention Plan
- Determine an interim alternative educational setting
- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This meeting has been scheduled for: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

The following are invited to attend and participate in the IEP meeting:

\_\_\_\_\_, Parent  
\_\_\_\_\_, Student  
\_\_\_\_\_  
\_\_\_\_\_

Principal/Designee \_\_\_\_\_  
General Education Teacher \_\_\_\_\_  
Special Education Teacher/ Case manager \_\_\_\_\_  
Guidance Counselor \_\_\_\_\_

The parent/adult student or school division may invite individuals who have knowledge or special expertise regarding the student to participate in this meeting. 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 \_\_\_\_\_ e-mail \_\_\_\_\_.

\* Copies of the evaluation report(s) to be used for eligibility determination are available to you two business days prior to the date of the eligibility meeting. These report(s) are located at the Lunenburg County School Board Office. If you need directions or have any questions contact the person listed directly above.

To the Parent \_\_\_\_\_ Student: \_\_\_\_\_ Date of Meeting: \_\_\_\_\_

Please check your choice. Detach and return this section to \_\_\_\_\_ Fax: \_\_\_\_\_

I, the parent,  I, the student, **will attend** this meeting as scheduled.

I, the parent,  I, the student, **cannot attend** this 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: \_\_\_\_\_

**LUNENBURG COUNTY PUBLIC SCHOOLS  
SPECIAL EDUCATION SERVICES - MEETING NOTICE  
Student Notice**

To: \_\_\_\_\_

Date Sent to Participants: \_\_\_\_\_

This is to notify you that a team meeting has been scheduled for the above named 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:

- \_\_\_ Determine the need for an initial evaluation for special education and related services
- \_\_\_ Determine the needed evaluation component(s) for an initial evaluation for special education and related services
- \_\_\_ Determine the need for a re-evaluation for special education and related services
- \_\_\_ Determine the needed evaluation components(s) for a re-evaluation for special education and related services
- \_\_\_ Determine initial eligibility for special education and related services\*
- \_\_\_ Determine continued eligibility for special education and related services\*

- \_\_\_ Consider changing the student's identified disability
- \_\_\_ Conduct a manifestation determination review prior to a change in placement i.e. a long term suspension or expulsion and including removal to an interim alternative educational setting
- \_\_\_ Develop a Functional Behavioral Assessment plan
- \_\_\_ Develop a Behavioral Intervention Plan
- \_\_\_ Review and/or revise a Behavioral Intervention Plan
- \_\_\_ Determine an interim alternative educational setting
- \_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This meeting has been scheduled for: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

The following are invited to attend and participate in the IEP meeting:

\_\_\_\_\_, Parent  
\_\_\_\_\_, Student  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The parent/adult student or school division may invite individuals who have knowledge or special expertise regarding the student to participate in this meeting. 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 \_\_\_\_\_ e-mail \_\_\_\_\_.

\* Copies of the evaluation report(s) to be used for eligibility determination are available to you two business days prior to the date of the eligibility meeting. These report(s) are located at the Lunenburg County School Board Office. If you need directions or have any questions contact the person listed directly above.

To the Student Student: \_\_\_\_\_ Date of Meeting: \_\_\_\_\_

Please check your choice. Detach and return this section to \_\_\_\_\_ Fax: \_\_\_\_\_

- \_\_\_ I, the parent, \_\_\_ I, the student, **will attend** this meeting as scheduled.
- \_\_\_ I, the parent, \_\_\_ I, the student, **cannot attend** this 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: \_\_\_\_\_

# Lunenburg County Public Schools

## SPECIAL EDUCATION DEPARTMENT

Lunenburg School Board Office

Kenbridge, VA 23944

### TEAM REVIEW FOR EVALUATION

DATE: \_\_\_\_\_

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_ RACE: \_\_\_\_\_ GENDER: M or F

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ STUDENT TESTING ID #: \_\_\_\_\_

PARENT(S)/GUARDIAN(S): \_\_\_\_\_

MAILING & 911  
COMPLETE ADDRESS: \_\_\_\_\_

TELEPHONE: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ (CELL) \_\_\_\_\_

Reason for evaluation: **(MUST ATTACH ALL INTERVENTION AND CHILD STUDY DOCUMENTATION)**

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Summarize review of existing evaluation data:

1. Evaluations and information provided by the parents of the child
2. Current classroom-based assessments and observations
3. Observations by the teachers and related service providers
4. Local and state assessment
5. Academic achievement of the student

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Identify, on the basis of the above review and input from the child's parent(s), what additional data, if any, are needed to determine:

1. Whether the child continues to have a particular disability or has any additional disabilities.
2. The present levels of performance and educational needs of the child.
3. Whether the child continues to need special education and related services.
4. Whether any modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the IEP of the child and to participate, as appropriate, in the general curriculum.

Student Name: \_\_\_\_\_ STUDENT TESTING ID # \_\_\_\_\_

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Additional data is needed.                       No additional data is needed.

In order to obtain the needed information above, check the additional components that are needed.

YES	NO	EVALUATIONS
		<b>EDUCATIONAL</b> All classroom teachers must complete Student Educational Classroom Performance Packet and forward to SPED office 5 days prior to eligibility.
		<b>DEVELOPMENTAL</b>
		<b>SOCIOCULTURAL</b>
		<b>PSYCHOLOGICAL/PSYCHOEDUCATIONAL</b> <input type="checkbox"/> Behavior Rating Scale
		Check all that apply: <b>MEDICAL</b> <input type="checkbox"/> Physical Exam <input type="checkbox"/> Records *Attach Signed Medical Form(s)    *Attach Signed Release Form(s).
		<b>SPEECH AND LANGUAGE</b>
		<b>HEARING SCREENING</b> May use Pre-Referral Screening if tested adequate – no need for follow-up. If applicable, ATTACH RESULTS. (Hearing screening is a required component prior to initial determination of eligibility for special education services.)
		<b>VISION SCREENING</b> May use Pre-Referral Screening if tested adequate – no need for follow-up. If applicable, ATTACH RESULTS. <input type="checkbox"/> Functional Vision Assessment
		<b>CLASSROOM OBSERVATION</b> TO BE COMPLETED BY: _____
		<b>CLASSROOM PERFORMANCE</b> TO BE COMPLETED BY: _____
		<b>Occupational Therapy (OT)</b>
		<b>Physical Therapy (PT)</b> * Attach a prescription from a licensed physician for initial evaluations
		<b>OTHER</b>

**SIGNATURE OF PERSONS PARTICIPATING IN THIS IEP MEETING**

\_\_\_\_\_  
Parent    Date

\_\_\_\_\_  
Name/Relationship to Student    Date

\_\_\_\_\_  
Student (as appropriate)    Date

\_\_\_\_\_  
Name/Relationship to Student    Date

\_\_\_\_\_  
Principal or Designee    Date

\_\_\_\_\_  
Name/Relationship to Student    Date

\_\_\_\_\_  
Special Education Teacher    Date

\_\_\_\_\_  
Name/Relationship to Student    Date

\_\_\_\_\_  
General Education Teacher (as appropriate)    Date

\_\_\_\_\_  
Name/Relationship to Student    Date

*NOTE: Parents shall receive written prior notice and parental rights. Consent shall be obtained if evaluations are being requested. An evaluation shall be completed if the parents request the evaluation.*



### ASSESSMENT COMPONENTS

Please check assessments components identified.

**EDUCATIONAL:** A written report describing current educational performance and identifying instructional strengths and weaknesses in academic skills and language performance. Completed by educators and/or psychologists.

**DEVELOPMENTAL:** A written report of assessment in the major areas of development, including cognition, motor skills, social/adaptive behavior, perception, and communication. Completed by appropriate professionals (including psychologists, physicians, therapists).

**SOCIOCULTURAL:** A written report from a qualified visiting teacher or school social worker based on the use of information collected through social appraisal instruments. It shall contain social background and social/adaptive behavior in home, school, and community.

**PSYCHOLOGICAL:** A written report from a qualified psychologist based on the use of a battery of appropriate instruments, which include individual ability/intelligence test(s) and psycho educational test(s).

**MEDICAL:** A written report from a licensed physician indicating general medical history and any medical/health problems, which may impede learning.

**SPEECH AND LANGUAGE:** A written report to evaluate your child's articulation, voice, fluency, expressive language, and receptive language. Completed by a speech and language Pathologist or therapist.

**HEARING:** An audiometric screening of hearing conducted by a speech and language therapist, hearing teacher, or nurse.

**VISION:** A Snellan chart screening completed by a school nurse.

**OBSERVATION:** Observation of academic performance in the regular classroom completed by a team member other than the child's regular teacher.

**OCCUPATIONAL THERAPY (OT):** A review of visual motor and fine motor skills.

**PHYSICAL THERAPY (PT):** A review of gross motor skills.

**CLASSROOM PERFORMANCE:** A written report of grades, standardized test, strengths, weakness and work habits.

**NO DATA:** No additional data is needed

**OTHER** \_\_\_\_\_  
\_\_\_\_\_

List any others and describe: **MUST INCLUDE A DESCRIPTION**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Parent(s) / Adult Student initials here indicate a copy of rights and procedural safeguards for special education have been given to the parent. (initial evaluation, re-evaluation, IEP).

Procedural Safeguards Notice must be given to parents at a minimum upon:

- Initial referral for evaluation
- The parent requests a copy
- Once a year rights are given to parents
- Receipt of a request for a due process hearing

**LUNENBURG COUNTY PUBLIC SCHOOLS  
SPECIAL EDUCATION SERVICES - PRIOR NOTICE -PROPOSAL**

**Student's Name:** \_\_\_\_\_ **Student Testing ID#:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The Lunenburg County Public Schools offers many special programs and services. At this time, we propose the following actions:

\_\_\_\_\_ That the above named student is a student with a disability and is eligible / continues to be eligible for special education and related services. We must have your written permission for eligibility (consent form attached). This decision was based on the evaluation(s) conducted and discussed at the eligibility meeting (minutes attached) held on \_\_\_ / \_\_\_ / \_\_\_ which you did / did not attend.

\_\_\_\_\_ Initiate a change in the above named student's identification from \_\_\_\_\_ to \_\_\_\_\_. Before we can initiate this change in your child's identification we must have your written permission (consent form attached). This change is based on the re-evaluation(s) conducted and discussed at the eligibility meeting (minutes attached) held on \_\_\_ / \_\_\_ / \_\_\_ which you did / did not attend.

\_\_\_\_\_ Terminate the provision of all special education and related services for the above named student. Before we can initiate this change we must have your written permission (consent form attached). This decision that the above named student is no long eligible for special education and related services was made at the meeting (minutes attached) held on \_\_\_ / \_\_\_ / \_\_\_ which you did / did not attend.

\_\_\_\_\_ Terminate the eligibility for all special education and related services for the above named student as the result of graduation with a standard diploma or advanced studies diploma. This will occur upon graduation on \_\_\_ / \_\_\_ / \_\_\_.

\_\_\_\_\_ Initial evaluation to determine eligibility for special education and related services.

\_\_\_\_\_ Re-evaluation to determine continued eligibility for special education and related services.

\_\_\_\_\_ No additional data is needed

\_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE:** You have previously received a copy of procedural safeguards which explains your rights pertaining to the proposed action(s). This includes your right to appeal this decision. If you, the parent(s) and adult student, need another copy of the procedural safeguards or need assistance in understanding this information please contact \_\_\_\_\_ at \_\_\_\_\_ or e-mail \_\_\_\_\_ or contact \_\_\_\_\_ at \_\_\_\_\_ or e-mail \_\_\_\_\_

**Explanation of why the Lunenburg County Public Schools has proposed to take this action:**

**Description of any options the Lunenburg County Public Schools considered and the reasons why those options were proposed:**

**Description of the nature, purpose, and use of any evaluation procedure, test, record, or report the Lunenburg County Public Schools used as a basis for the proposal:**

**Description of any other factors which are relevant to the proposal:**

**LUNENBURG COUNTY PUBLIC SCHOOLS  
SPECIAL EDUCATION SERVICES - PRIOR NOTICE - REFUSAL**

**Student's Name:** \_\_\_\_\_ **Student Testing ID#:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_

After consideration Lunenburg County Public Schools has decided:

- \_\_\_ To refuse to conduct an initial evaluation.
- \_\_\_ To refuse to conduct a re-evaluation/evaluation.
- \_\_\_ That the above named student is **not** eligible for special education and related services. This decision was made at the eligibility meeting (minutes attached) held on \_\_\_\_/\_\_\_\_/\_\_\_\_ which you did / did not attend .
- \_\_\_ To refuse to make a change in the above named student's identification from \_\_\_\_\_ to \_\_\_\_\_ . This decision was made at the eligibility meeting (minutes attached) held on \_\_\_\_/\_\_\_\_/\_\_\_\_ which you did / did not attend .
- \_\_\_ To refuse to terminate the provision of all special education and related services for the above named student. This decision was made at a meeting (minutes attached) held on \_\_\_\_/\_\_\_\_/\_\_\_\_ which you did / did not attend .
- \_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE:** You have previously received a copy of procedural safeguards which explains your rights pertaining to the proposed action(s). This includes your right to appeal this decision. If you, the parent(s) and adult student, need another copy of the procedural safeguards or need assistance in understanding this information please contact \_\_\_\_\_  
at \_\_\_\_\_ or e-mail \_\_\_\_\_ or contact \_\_\_\_\_  
at \_\_\_\_\_ or e-mail \_\_\_\_\_

Explanation of why the Lunenburg County Public Schools has refused to take this action:

Description of any options the Lunenburg County Public Schools considered and the reasons why those options were rejected:

Description of the nature, purpose, and use of any evaluation procedure, test, record, or report the Lunenburg County Public Schools used as a basis for the refusal:

Description of any other factors which are relevant to the refusal:



LUNENBURG COUNTY PUBLIC SCHOOLS  
SPECIAL EDUCATION SERVICES – CONSENT

Student's Name: \_\_\_\_\_ Student Testing ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Lunenburg County Public Schools needs your written consent to the following proposed actions:

\_\_\_\_\_ **Parent(s)/Adult Student initials** here indicate that the parent(s)/adult student has read the prior notice regarding this proposed action before giving permission to implement this proposed action.

1. \_\_\_\_\_ a. The above named student is a student with a disability and is **eligible** for special education and related services.  
IDENTIFICATION: \_\_\_\_\_
- \_\_\_\_\_ b. The above named student is a student with a disability and **continues to be eligible** for special education and related services.  
IDENTIFICATION: \_\_\_\_\_
2. \_\_\_\_\_ Change the above named student's identification from \_\_\_\_\_ to \_\_\_\_\_.
3. \_\_\_\_\_ NOT ELIGIBLE for special education and related services
4. \_\_\_\_\_ Terminate the provision of all special education and related services for the above named student.
5. \_\_\_\_\_ Initial evaluation to determine eligibility for special education and related services.
6. \_\_\_\_\_ Re-evaluation to determine continued eligibility for special education and related services.
7. \_\_\_\_\_ No additional data is needed
8. \_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE CHECK ONE**

\_\_\_\_\_ I do give my permission for Lunenburg County Public Schools to implement the above action

\_\_\_\_\_ I do not give my permission for Lunenburg County Public Schools to implement the above action

\_\_\_\_\_  
Signature of Parent/ Adult Student

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Return this to:

Date received by the school: \_\_\_\_/\_\_\_\_/\_\_\_\_

**LUNENBURG COUNTY PUBLIC SCHOOLS**  
 SPECIAL EDUCATION DEPARTMENT  
 Lunenburg School Board Office  
 Post Office Box 710 • 1009 Main Street • Kenbridge, Virginia 23944

Phone: (434) 676-2467

Fax: (434) 676-6167

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

This is to authorize Lunenburg County Special Education Department  
 to **OBTAIN FROM** or **RELEASE** to:

Name of Agency, Hospital, Doctor, Institution, Company		<ul style="list-style-type: none"> <li>• Medical records will not be released to any person without prior written consent of parent, guardian, surrogate, or *student specifying which of these records are to be released and to whom.</li> <li>• All relevant records with respect to the identification, evaluation, and placement of your child will be maintained in the school and available for your examination on an appointment basis.</li> <li>• This authorization remains in effect for one year unless withdrawn by the parent, guardian, surrogate, or * adult student in writing.</li> <li>• A photostatic copy of this release will be as valid as the original.</li> </ul>
Address		
TELEPHONE & FAX:		
The following information only:	<input type="checkbox"/> Medical Records <input type="checkbox"/> Social History <input type="checkbox"/> Educational Eval. <input type="checkbox"/> Psychological Eval. <input type="checkbox"/> Speech/Language Eval. <input type="checkbox"/> Individual Education Program (IEP) <input type="checkbox"/> Eligibility Minutes/Recommendations <input type="checkbox"/> Other _____ _____ _____	
For the purpose of:	<input type="checkbox"/> Educational Planning <input type="checkbox"/> Other _____ _____ _____ _____	
This information pertinent to:	Name _____ D.O.B. _____ Address _____ City & State _____	

DATE ____/____/____ MONTH DAY YEAR	SIGNATURE OF PARENT/GUARDIAN/SURROGATE/ADULT STUDENT*
DATE ____/____/____ MONTH DAY YEAR	SIGNATURE OF ADULT STUDENT*

\* Student(s) 18 years or older must authorize release/disclosure of confidential information.

***This information is to ONLY be released to central office special education personnel at the address or fax listed above.***