

SANTA CLARA COUNTY ASSESSMENT PLAN

Initial Annual Triennial Transition Interim Other _____

To Parent or Guardian of _____ Date ____ / ____ / ____

District _____ School _____ Grade _____ Birthdate ____ / ____ / ____

Primary language _____ English proficiency/CELDLT Level _____

_____ has been referred and/or recommended for an assessment by the following individual(s):

 Parent (Signature) Nurse (Signature) Teacher (Signature) Sp Ed Teacher (Signature)

The reason for the referral for assessment is _____

The district proposes to assess your child to determine his/her eligibility for special education services or continued eligibility and present levels of academic performance and functional achievement. Your child will be assessed in all areas of suspected disability as needed. To meet your child's individual education needs, this assessment will consist of an evaluation in only the areas checked by the local educational agency (LEA/district). *Tests conducted pursuant to these assessments may include, but are not limited to classroom observations, rating scales, one-on-one testing or some other types or combination of tests.

Evaluation Area	Examiner Title
<input type="checkbox"/> Academic Achievement – These tests measure reading, spelling, arithmetic, oral and written language skills, and/or general knowledge.	
<input type="checkbox"/> Health – Health information and testing is gathered to determine how your child's health affects school performance.	
<input type="checkbox"/> Intellectual Development – These tests measure how well your child thinks, remembers, and solves problems.	
<input type="checkbox"/> Language/Speech Communication Development – These tests measure your child's ability to understand and use language and speak clearly and appropriately.	
<input type="checkbox"/> Motor Development – These tests measure how well your child coordinates body movements in small and large muscle activities. Perceptual skills may also be measured.	
<input type="checkbox"/> Social/Emotional – These scales will indicate how your child feels about him/herself, gets along with others, and takes care of personal needs at home, school and in the community.	
<input type="checkbox"/> Adaptive/Behavior	
<input type="checkbox"/> Post Secondary Transition – Age appropriate transition assessments related to training, education, employment and where appropriate independent living skills.	
<input type="checkbox"/> Other _____	
<input type="checkbox"/> Alternative Means of Assessment – Describe alternative methods of assessing the child, if applicable _____	

I consent to the assessment. I understand that the results will be kept confidential and that I will be invited to attend the IEP team meeting to discuss the results. I also understand that no special education services will be provided to my child without my written consent.

I do not consent to the proposed assessment described above.

I would like the following assessment information to be considered by the IEP team: _____

Parent/Guardian Signature _____ Date ____ / ____ / ____

Address: _____

Phone Number: (____) _____

Comments: _____