Student Assistance Team
Permission to Screen

Based on the Student Assistance Team's recommendations, I, _____ hereby authorize personnel of the Tuscola
Parent/Guardian
Intermediate School District and/or _____ to
Local School District
gather pertinent information and observe my child, _____
Student's Name
_____ _____ in order to determine the best educational
Teacher/Grade DOB
program for him/her.

This may include:

____ **Record Review**
____ **Observation**
____ **Central Auditory Processing Screening**
____ **Student Interview**
____ **Rating Scales**
____ **Functional Vision Screening**
____ **Academic Screening**
____ **ADHD Screening**
____ **Teacher Interview**
____ **Other** _____

The following professionals may be involved:

____ **Occupational Therapist**
____ **School Psychologist**
____ **Speech/ Language Therapist**
____ **School Counselor/Social Worker/Liaison**
____ **Physical Therapist**
____ **School Social Worker**
____ **Special Education Teacher**

This is not an evaluation for special education services. Your permission will be needed for further evaluation of a suspected special education eligibility.

Signed_____ _____
Parent/guardian signature Date

Address_____ _____ _____
House # Street Phone

_____ _____ _____
City State Zip Code