

Your child has been referred for an assessment to determine the need for Assistive Technology Support.

STUDENT: _____

ADDRESS: _____

DATE: _____

DATE OF BIRTH: _____

SCHOOL: _____

SCHOOL DISTRICT OF RESIDENCE: _____

PHONE NUMBER HOME: _____

WORK: _____

Please sign below indicating your permission for your child to have an assessment by the Educational Consultant for Assistive Technology. Please return using the enclosed envelope.

_____ **I do wish that my child have an assessment to determine the need for Assistive Technology Support.**

_____ **I do not wish that my child have an assessment to determine the need for Assistive Technology Support.**

Parent/Guardian Signature

*******Please send any medical notes that you may have to help us do our assessment**

