



## PARENTAL CONSENT FOR STUDENT EVALUATION AND EXCHANGE OF INFORMATION

**Student Name:** \_\_\_\_\_  
**Education Coordinator:** Greg Bramwell  
**Phone:** (208) 227-2225  
**Fax:** (208) 227-2364

**School:** Teton Peaks Academy  
P.O. Box 2077  
Idaho Falls, Idaho 83403

Teton Peaks Academy requests your permission to review academic and special education records from schools your child has attended. We will then conduct an evaluation or re-evaluation of your child's educational strengths and needs. Your child may be eligible for special education services, such as an Individualized Education Program (IEP).

I, \_\_\_\_\_ (parent or guardian), give my permission for Teton Peaks Academy to exchange information with \_\_\_\_\_ (School) concerning my child \_\_\_\_\_ (child's full name) for the purpose of determining appropriate educational placement and services.

**The following areas may be evaluated.**

**Intellectual Ability**

Wechsler Intelligence Scale for Children – IV (WISC IV)

**Academic Functioning**

Wechsler Individual Achievement Test-II (WIAT-II)

Woodcock-Johnson Achievement Test-Revised (WJ-R)

Your involvement in the evaluation process is important. If there are additional areas you would like to have assessed or if you would like to have more input regarding these assessments, please contact the Education Coordinator. The information gathered is confidential and will be shared only with those professionals who have contact with your child and any other person you designate by your expressed written permission.

You will be contacted and invited to review the results of the assessments. No change will be made in your child's educational program without your permission. You have the legal right to accept or reject the services recommended.

**Check one:**     Permission is **given** to conduct this evaluation.                       Permission is **denied** to conduct this evaluation.

Signature: \_\_\_\_\_

Home phone: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Work phone: \_\_\_\_\_

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

Cell phone: \_\_\_\_\_

The evaluation of your child will be completed within 30 days of signed consent.