MUSKEGON AREA INTERMEDIATE SCHOOL DISTRICT
INITIAL REFERRAL FOR SPECIAL EDUCATION SERVICES

Student's Name _____ Birthdate ___/___/___ Sex _____

Student's Social Security Number _____ CIMS Student No._____

Address _____ City _____ Phone _____

Building _____ District _____ Grade _____

Parent/Guardian _____ Teacher _____

Referred By _____ Date ___/___/___ Administrator _____
(Signature)

INITIAL EVALUATION – There is reasonable cause to suspect that this child is in need of special education services.
Reason for concern: _____

_____

_____

_____

_____

During the evaluation described above the following school personnel may be involved: School Psychologist, Teacher Consultant, School Social Worker, Teacher of the Speech and Language Impaired, Physical Therapist, Occupational Therapist, Resource Teacher, Audiologist, Orientation and Mobility Specialist.

PARENTAL CONSENT Return this form with your signature within 7 days to:
Date Sent: ___/_____/_____

_____

_____

_____

❒ I have received and understand my due process rights and have reviewed the additional information about special education contained on the reverse side of this form and give my permission for the evaluation described above.

❒ I do not give my permission for the evaluation described above.

Parental Signature _____ Date ___/_____/_____

Language of Student/Parent _____

FOR OFFICE USE ONLY

Date Consent Received _____/_____/_____
Date IEPT Due _____/_____/_____

MET Members or Staff Assigned: _____Date_____/_____/_____