

# KERN EARLY START SERVICES

- KERN REGIONAL CENTER - (661) 327-8531 • FAX (661) 327-8676
- BAKERSFIELD CITY SCHOOL DISTRICT SELPA - (661) 631-5850 • FAX (661) 631-3289
- KERN COUNTY CONSORTIUM SELPA - (661) 636-4817 • FAX (661) 636-4810
- SIERRA SANDS SCHOOL DISTRICT SELPA - (760) 446-8073 • FAX (760) 446-8074

- Initial
- Transition
- Special

## CONSENT FOR EVALUATION AND ASSESSMENT SERVICES

### TO THE PARENT GUARDIAN OF:

Date

Child's Name (First, Middle, Last) \_\_\_\_\_

Birthdate \_\_\_\_\_

Referral Date \_\_\_\_\_

The reason for the requested evaluation and assessment is to consider the child for Early Start Services because of a suspected disability or medical condition resulting in delays in development.

Evaluation and assessment will help to determine whether your child needs to begin or continue receiving services from local agencies participating in the Individual with Disabilities Education Act Part C, California Early Start Services. These tests will help identify your child's strengths and areas of need. Evaluation and assessment may include: 1) observations of your child at home or other appropriate settings; 2) an interview with you; 3) review of medical and other reports you agree to share; and 4) tests. These tests may include some or all of the following areas:

✓ IF APPLICABLE	DEVELOPMENTAL AREAS	SKILLS
	Gross Motor	Coordinated movement of large muscles, i.e., balance, crawling, walking, running, including orientation and mobility.
	Fine Motor	Coordinated movement of small muscles, especially hands and arms, i.e., grasping, drawing, manipulating objects.
	Cognitive	Perception, processing, storage and recall of information either seen or heard, i.e., discrimination, memory, relationships and problem solving.
	Language/Communications	Ability to receive and understand information and show comprehension through speech, gestures or writing.
	Social/Emotional/Family	Behavioral adjustment to society and relationships with others and self; family information which may include resources, priorities and concerns.
	Self-Help	Ability to care for self; i.e., dressing, grooming, toileting, eating/feeding.
	Health	Vision*, hearing*, general health and physical development, medical status.

\*Documentation of evaluation/status required.

Professionals participating in the evaluation and assessment may include:

- |                                                        |                                                 |                                                                            |
|--------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Special Education Teacher     | <input type="checkbox"/> Nurse                  | <input type="checkbox"/> Psychologist                                      |
| <input type="checkbox"/> Speech & Language Pathologist | <input type="checkbox"/> Audiologist            | <input type="checkbox"/> Occupational Therapist                            |
| <input type="checkbox"/> Social Worker                 | <input type="checkbox"/> Interpreter            | <input type="checkbox"/> Physical Therapist                                |
| Agency: _____                                          | <input type="checkbox"/> Other (specify): _____ | <input type="checkbox"/> Assessment/Service Coordinator                    |
| <input type="checkbox"/> Infant Development Specialist | <input type="checkbox"/> Physician              | Agency: <input type="checkbox"/> KRC <input type="checkbox"/> Other: _____ |

For more information about the evaluation and your legal rights (summary on back), please call: \_\_\_\_\_, Service Coordinator, at ( ) \_\_\_\_\_.

Child's Primary Language:  English  Spanish  Tagalog  Ilocano  Sign  Other: \_\_\_\_\_

- I have reviewed my legal rights printed on the back of this form and give permission for the evaluation and assessment as described. I understand that the evaluation and assessment information will be used to help determine if my child is eligible for services and what services may be needed. However, services will be provided only with my written consent. I also understand that I will obtain a copy of the evaluation and assessment results completed.
- I have received a copy of the expanded Parents' Rights.
- I do not want my child evaluated at this time.

Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

Witness/Interpreter \_\_\_\_\_

Date \_\_\_\_\_

White: LEA      Canary: Kern Regional Center      Pink: Parent/Legal Guardian