Streator Township High School
District #40
202 W. Lincoln Avenue
Streator, Illinois 61364-2102
Phone: 815.672.0545
Fax: 815.673.7665

PARENT CONSENT FOR AGENCY INVITATION TO TRANSITION MEETING

Dear Parent/Guardian of ____

Your child's annual IEP meeting, including consideration of needed post-secondary goals and transition services, will be held this school year. To the extent appropriate, we must invite a representative of the agency or agencies which may be responsible for providing post-secondary transition services. In order for us to invite these agency representatives, we need your written consent.

The specific agency/agencies that we would like to have represented at your child's IEP meeting are:

[X] **Department of Human Services Division of Rehabilitation Services (DRS)**
(e.g., local DRS counselor)

[ ] **Department of Human Services Division of Developmental Disabilities**
(e.g., case coordination or PAS agency encompassing our community)

[ ] **Division of Specialized Care for Children (DSCC)**

[ ] **Post-Secondary Education Disability Services**
(e.g., disability service office of any post-secondary education institution including community college, college, trade or vocational schools)

[X] **Other Agency: _________Streator Unlimited___________________________**
(e.g., community-based agencies such as the Center for Independent Living)

Please sign below indicating your consent or refusal for that agency to be invited to the IEP meeting.

Please choose one.

[x] I **Do** give my consent to have the above listed agency/agencies invited to IEP meetings. I understand that my consent is voluntary and may be revoked at any time before the identified agency representatives have been invited to the IEP meeting.

[ ] I **Do Not** give my consent to have the above-listed agency/agencies invited to IEP meetings.

____ _________________________

Signature of Parent/Guardian Date

Streator Township High School

District #40

202 W. Lincoln Avenue
Streator, Illinois 61364-2102
Phone: 815.672.0545
Fax: 815.673.7665

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I, PARENT/GUARDIAN OF ___, hereby authorize the exchange of communications and the (Name of parent, guardian, or emancipated adult student)

release/exchange of the following records concerning ________________________________
(Name of student)

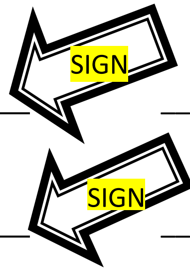
between ____Streator High School____________ agents and employees and the following:
(Name of district or cooperative)

☒	Department of Human Services/DHS	☒	Illinois Valley Community College (IVCC)
☐	Friendship Village	☐	Streator Unlimited
☐	Horizon House	☐	Youth Service Bureau (YSB)
☐	Illinois Valley Center for Independent Living	☐	Other ________________________________

These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq.,* and are to be made for the purpose of educational planning for ________________________________
(Name of student)

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for ________________________________
(name of student)

This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.



________________________________ ________________
PARENT/GUARDIAN SIGNATURE DATE

________________________________ ________________
STUDENT SIGNATURE (for mental health/ developmental disability records, if student is age 12 or older) DATE

________________________________ ________________
WITNESS SIGNATURE (for mental health records) DATE

* NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Streator Township High School

District #40

202 W. Lincoln Avenue
Streator, Illinois 61364-2102
Phone: 815.672.0545
Fax: 815.673.7665

PARENTAL CONSENT FOR BILLING PUBLIC INSURANCE (Medicaid)

This notification is provided to the parents/guardians of all special education students. We do so to avoid having to ask about family finances and insurance decisions.

If your child receives special education services and is also Medicaid eligible, the school district can seek partial reimbursement for Medicaid for health services documented in your child's Individualized Education Program (IEP). Medicaid reimbursement is a source of federal funds approved by Congress to help school districts maintain and improve diagnostic and therapeutic services for students.

The reimbursement process requires the school district to provide Medicaid with your child's name, birthdate and Medicaid number. Federal law requires your written consent to release these data to Medicaid.

- Only data for Medicaid eligible students will be released.
- You can deny the district the right to release this data now or at any time in the future.
- Regardless of your decision the district must continue to provide, at no cost to you, the services listed in your child's IEP.

When considering your decision, please note that this program has **no impact** on current or future Medicaid benefits for you, the student or your family. Under federal law, your decision to participate in this program CANNOT:

- Decrease lifetime coverage or any other public insurance benefit,
- Result in the family paying for services that would otherwise be covered by Medicaid,
- Increase your premiums or lead to discontinuation of benefits or insurance, or
- Result in the loss of eligibility for home and community-based waivers.

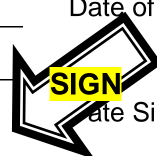
Your consent allows us to recover a portion of the costs associated with providing health services to your child.

☐ I approve of the district releasing data to Medicaid.

☐ I do not approve of the district releasing data to Medicaid.

Student's Name: ______________________ Date of Birth: ______________

Parent/Guardian's Name: ______________________



Parent/Guardian's Signature: ______________________ Date Signed: ______________

CollegeBoard

Services for Students with Disabilities

Consent Form for Accommodations Request

Student Information

Student Name: ____________________

School: STREATOR HIGH SCHOOL, DISTRICT #40

Student Date of Birth: ____________________

Student and Parent/Guardian Signature

I wish to apply for testing accommodation(s) on College Board tests (SAT, PSAT/NMSQT, and/or Advanced Placement Exams) due to disability. I authorize my school: to release to the College Board copies of my records that document the existence of my disability and need for testing accommodations; to release any other information in the school's custody that the College Board requests for the purpose of determining my eligibility for testing accommodations on College Board tests; and to discuss my disability and accommodation needs with the College Board. I also grant the College Board permission to receive and review my records, and to discuss my disability and needs with school personnel and other professionals. I agree to the conditions set forth in the student bulletins for the SAT, AP, and PSAT/NMSQT Programs relating to accommodations for disabilities.

Student Signature: ____________________ Date: __________

Parent/Guardian Signature: ____________________ Date: __________

(Parent/guardian signature is required if Student is under 18.)

Instructions to the School

This form must be used when a request for accommodation(s) is submitted electronically (via SSD Online). The form should be maintained by the school with the student's records. It does not need to be sent to the College Board. You will be asked to verify that a signed Consent Form is on file at the school prior to submitting a request for accommodations.