



DOC
TYPE 7641

DATE (MM/DD/YY)			_____
PRINT STUDENT'S NAME	(LAST)	(FIRST)	(M.I.)
STUDENT ID. NO.			_____

NOTICE OF INTENT AND PARENTAL/GUARDIAN CONSENT TO CONDUCT AN ASSISTIVE TECHNOLOGY ASSESSMENT

To the Parent(s) or Guardian(s) of: _____

An Assistive Technology Assessment is being requested in order to determine if there are assistive technology tool(s) and/or strategies that your child may need to access the curriculum in one or more of the following curriculum areas: Writing/Composing, Reading, Math, Learning Strategies, and Communication.

An Assistive Technology Assessment includes at least one trial of a tool or tools in the student's learning environments and documentation of the results obtained from the trial.

After the assessment/trial period, an IEP meeting may be scheduled with you to discuss the results of the assessment and to document the AT tools and strategies that are needed to support your child in meeting his/her IEP goals.

Before returning this notice, please complete the following: (Check all that apply)

- Yes No I/We understand the reason for this assessment.
- Yes No I/We request a meeting to discuss this proposed assessment.
- Yes No I/We give consent for this assessment. If yes, Please sign and date.

Consent: _____ (Parent/Guardian Signature) _____ (Date)

Please return this form and address any questions about this screening to:

_____ at _____
(Name/Title) (Telephone)

_____ at _____
(Name/Title) (Telephone)