

REQUESTING OFFICE NAME AND ADDRESS

ATTACH LABEL OR TYPE IN CLAIMANT NAME

## REQUEST FOR ADMINISTRATIVE INFORMATION

Please ask the person(s) most familiar with the child's records to complete this form.

Continue any answers as needed on next page.

Name of School

1. Has there been any recent evaluation or testing of this child? If yes, kind(s) of test / evaluation:	Date(s):

Please send us copies of all comprehensive evaluations, triennial assessments, psychological or speech/language testing, current Individualized Education Programs, teacher/therapist progress reports, and all other records that can help us evaluate the child's functioning.

2. Has the child been referred for assessment team evaluation or special class placement or services? If yes, to whom?	Date(s):

3. Current Instructional Levels	Standardized Assessment Instrument	Score/Percentile Rank	Date(s):
Reading Level:			
Math Level:			
Written Language Level:			

4. Grade(s) repeated, if any:

K	1	2	3	4	5	6	7	8	9	10	11	12
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Educational Disabilities, if any:

<input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Hearing Impairment/Deafness <input type="checkbox"/> Speech or Language Impairment <input type="checkbox"/> Visual Impairment/Blindness <input type="checkbox"/> Emotional Disturbance/Behavior Disorder <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Autism <input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Other Health Impairment (please specify) _____ <input type="checkbox"/> Specific Learning Disability (please specify) _____ <input type="checkbox"/> Developmental Delay (please specify) _____ <input type="checkbox"/> Multiple Disabilities (please specify) _____
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6. Placement and Related Services (Check all that apply):

<input type="checkbox"/> Regular Education, no special instruction <input type="checkbox"/> Special Ed. Instruction	Hours/week:	Therapies, etc:	Hours/week:
<input type="checkbox"/> Inclusion - Sp. instr. in regular class <input type="checkbox"/> Resource Room <input type="checkbox"/> Self-contained, regular school <input type="checkbox"/> Self-contained, special school <input type="checkbox"/> Special school, non-public <input type="checkbox"/> Residential	_____ _____ _____ _____ _____	<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech - Language Therapy <input type="checkbox"/> Counselling (please specify) _____ <input type="checkbox"/> Other (please specify) _____	_____ _____ _____ _____ _____

**PLEASE PROVIDE YOUR NAME AND TITLE ON THE NEXT PAGE**

