Requested by _____, title _____
Date _____

Livingston County Public Schools

Reason for referral (e.g. universal testing, grades, discipline referrals, etc.)

_____

I give permission for my child, _____, DOB _____, to be screened by qualified personnel in the following area(s):

_____ Communication (Speech/Language)
_____ Hearing
_____ Vision
_____ Motor
_____ Academic/Cognitive/Developmental
_____ Assistive Technology/Augmentative/Alternative Communication
_____ Behavior Observation(s)
_____ Light's Retention Scale

I will be notified of screening results. If I have questions or concerns, I will notify my child's building principal at _____.

(check YES or NO and return to your child's school principal):

_____ NO, I do not want my child screened.
_____ YES, I give permission for my child to be screened in the area(s) checked above.

_____ _____
Parent/Guardian Signature Date
(Building Principal will forward copies to appropriate staff person(s) who will complete screening.)

The Board of Education does not discriminate on the basis of race, color, national origin, age, religion, sex, genetic information, limitations due to pregnancy, childbirth, or related medical conditions, or disability in employment, educational programs or activities.

Completed by school administration:

Date received: _____ Date sent to school psychologist: _____

Administrator signature: _____

Reviewed/Revised: 12/08/2020