

**LOS ANGELES UNIFIED SCHOOL DISTRICT
Request for Special Education Assessment**

Complete this form if you wish to request an assessment to determine this student's eligibility to receive special education and/or related services. Once you have completed this form, return it to the person designated below. Within 15 days, you will receive a written response. Parents requesting an assessment should receive and complete the "Student Information Questionnaire."

A. Name of student (last/first/middle) _____ Date of birth _____

Student address _____ Phone() _____

Male Female Grade _____ Student's primary language _____

School of residence _____ School of attendance _____

B. Name of parent/guardian _____

Parent/Guardian address (if different than student) _____ Phone () _____

Name of referring person _____

What is your relationship to this student? ___ Mother ___ Father ___ Guardian ___ Other (specify) _____

If request is from someone other than parent/guardian, is the parent/guardian aware of request? Yes No

What are your concerns about this student? _____

PARENT/GUARDIAN ► I hereby request a special education assessment.

Signature _____ Date _____

C. IF DISTRICT STAFF MEMBER IS MAKING THE REQUEST: What prior actions/modifications have been taken to help this student?

Date:	Action/Modification:	Outcome:

DISTRICT STAFF MEMBER ► I hereby request a special education assessment.

Signature _____ Position _____ Date _____

RETURN THIS FORM TO:

D.
District contact _____ School/Office _____
Address _____ Phone () _____

ADMINISTRATIVE/OFFICE USE ONLY

E.
Date Request for Special Education Assessment provided: ____ / ____ / ____ by: mail conference other _____
Date received by school/office: ____ / ____ / ____ Date Assessment Plan/Response due: ____ / ____ / ____
(15 calender days after receipt of signed Request)
Request received by: _____ Position: _____ Date: ____ / ____ / ____
White action copy given to Administrator/Designee: _____ Date: ____ / ____ / ____
Name