Please complete this form for a student observation in an early childhood setting. This will assist the observer in planning for interventions and a time to visit the classroom. Please have the parent complete the consent form. Fax both forms to Valerie Hasting at 217-245-5533. To provide more information about the student, you may contact Valerie at 217-245-7174 ext 257 or vhasting@frsed.org.

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_Language\_\_\_\_\_\_\_\_\_\_\_

Program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Days and times child attends\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has the child attended the program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the child have an IEP? \_\_\_\_\_\_\_\_

Does the child receive any of the following services? Speech/Language OT PT Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Any significant background information (medical, social, etc)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are the behavioral concerns? (try to use “ing” words-hitting, throwing, flapping, spinning etc.)

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What setting and actual time does the behavior occur? (Circle time: 9:00-9:15, Center time: 1:00-2:00, During transitions: Throughout day, Snack: 10:00-10:15, Gross motor 2:45-3:00, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have any interventions been tried? \_\_\_\_\_\_\_ How long have the interventions been tried?\_\_\_\_\_\_\_\_\_\_\_

What interventions have been tried? (visual supports-pictures for transitioning, routine, etc.; removal from the environment; positive reinforcement; social scripts; etc.)

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How has the child’s behavior changed since implementing the intervention(s)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FOUR RIVERS SPECIAL EDUCATION DISTRICT**

936 West Michigan Avenue

Jacksonville, Illinois 62650-3113

Phone: (217) 245-7174 Fax: (217) 245-5533

TTY: (217) 245-1400

Website: <http://www.frsed.org>

**Student Observation Consent Form**

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School District \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serving School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your child has been referred for an observation. Four Rivers staff will observe your child to offer suggestions to school staff to assist with meeting the educational needs of your child. If it is determined that a full and individual evaluation would be recommended for your child, you will be notified.

 I give consent for the observation(s).

 I do not give consent for the observation(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

I understand that I can revoke my consent at any time. If I do not revoke this consent, it will expire automatically one year after signature of this form.