

# Kankakee Area Special Education Cooperative

## Consent for Release/Exchange of Student Records and Information

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby give permission to release/exchange copies of and/or share information contained within the Student's school student records listed below:

\_\_\_\_\_ **All School Student Records**, including but not limited to:  
 Cumulative-permanent record, special education records, grade reports, discipline records, health records, attendance records, test scores, copy of birth certificate, copy of physical for athletics and ISBE Form 33-78.

\_\_\_\_\_ **All Special Education Records**

\_\_\_\_\_ **Specific School Student Records** (checked below):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Medical Information         | <input type="checkbox"/> Social Histories  | <input type="checkbox"/> Psychological Evaluations        |
| <input type="checkbox"/> Psychiatric Evaluations     | <input type="checkbox"/> IEP               | <input type="checkbox"/> Speech/Language Evaluations      |
| <input type="checkbox"/> Health/Attendance records   | <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Physical Therapy Evaluations     |
| <input type="checkbox"/> ISBE Form 33-78             | <input type="checkbox"/> Test Scores       | <input type="checkbox"/> Occupational Therapy Evaluations |
| <input type="checkbox"/> Cumulative-Permanent Record |  | <input type="checkbox"/> Copy of Physical for Athletics   |
| <input type="checkbox"/> Other: _____                |  |   |

\_\_\_\_\_ **Other** (Specify): \_\_\_\_\_

This information is to be released/exchanged between:

School/Agency: \_\_\_\_\_

Kankakee Area Special Education Cooperative

Address: \_\_\_\_\_

AND 1 Stuart Drive, Kankakee, IL 60901-8947

Attn: \_\_\_\_\_

Attn: \_\_\_\_\_

These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq., and are to be made for the purpose of educational planning for \_\_\_\_\_ (student name).

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for \_\_\_\_\_ (student name).

I understand that this release/exchange of information is in effect through \_\_\_\_/\_\_\_\_/\_\_\_\_ (not to exceed one year), and that I may revoke consent for this release/exchange in writing at any time.

\_\_\_\_\_  
 Parent/Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness Signature  
 (for mental health/developmental disability records)

\_\_\_\_\_  
 Student

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

(for mental health/developmental disability records, if student is age 12 or older)