



Wabash – Miami Area Program for Exceptional Children

246 N 300 W • Wabash, Indiana 46992-8689 • Phone (260) 563-8871

S/L Therapist: _____

School Psych: _____

Corporation: _____

NOTIFICATION OF REQUEST FOR INITIAL EVALUATION

The following information must be forwarded IMMEDIATELY UPON PARENT OR SCHOOL PERSONNEL REQUEST FOR EVALUATION for a student: **(260) 563-2749**

Student name: _____ STN: _____

School: _____ Grade: _____ Sex: M F DOB: _____

Request made by: ___ Parent ___ School Personnel (title: _____)

General education Teacher: _____

Specific educational concerns (ie: Reading, Math, behavior/emotional, speech, etc.):

YES NO School Personnel have attempted interventions to address concerns listed above. (if YES, check one:)

___ These interventions **DO NOT** use scientific, research-based interventions with sufficient progress monitoring data available to determine eligibility for services to address all of the specific educational concerns listed above.

-or-

___ These interventions **DO** use scientific, research-based interventions with sufficient progress monitoring data available to determine eligibility for services to address all of the specific educational concerns listed above.

Mental health or medical condition/diagnosis: _____

Medications: _____

Parent name: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Custody:

___ (01) Natural Parents ___ (02) Maternal Parent ___ (03) Paternal Parent ___ (04) Ward of Court

___ (05) Ward of DMH ___ (06) Ward of DPW ___ (07) Nursing Home ___ (08) Foster Parent(s)

___ (09) Other _____

Principal's signature

Date