Eastern Illinois Area of Special Education, 5837 Park Drive, Charleston, IL 61920

For Office Use Only
Date Received EIASE:
_____

REQUEST FOR STUDENT ASSISTANCE

(This is not a request for case study evaluation. Please forward this form to the EIASE Data Manager.)

Student Name *last* *first* *middle*

Parent's Name: Address: Phone:

DOB: M/F: Teacher: Grade:

Resident District: Attendance District Building:

Date Completed: Requested by:

IEP Case Manager (if applicable)

Reason(s) for Requesting Assistance:

Question(s) which need(s) to be addressed:

Assistance Requested: (Check all departments that apply.)

_____ Social Work
_____ Hearing (Audiological)
_____ Hearing Impaired Itinerant Services
_____ Vocational Education
_____ Behavioral Collaborative

_____ Early Childhood
_____ Vision
_____ Psychology
_____ Adapted P.E.

_____ Occupational Therapy
_____ Physical Therapy
_____ Autism Team
_____ Other (please specify)
_____

Please include a consent form for non-case study evaluation complete with parent signature.

Administrator's signature required: X

(Name, Title) (Date Signed)

Contact # _____

FOLLOW-UP SUMMARY (For EIASE Use Only) Date: _____

Completed by: _____

Participants:

Specific Actions to Be Taken: