



**EASTERN ILLINOIS AREA OF SPECIAL EDUCATION**  
5837 PARK DRIVE  
Charleston, IL 61920  
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## WAIVER OF TEN CALENDAR DAY NOTICE/CONSENT REQUIREMENTS

Name of Child	Date of Birth	Name of Parent/Guardian

I, the parent/guardian of \_\_\_\_\_ understand that any waiver of notice/consent requirements is voluntary. I understand that I may withdraw this waiver anytime prior to the event(s) checked below.

### CHECK ONE:

**I AGREE**

**I DO NOT AGREE**

to waive the requirements of a ten (10) calendar day interval prior to:

PARENT/GUARDIAN NOTIFICATION OF EVALUATION PLANNING CONFERENCE.

PARENT/GUARDIAN CONSENT FOR EVALUATION.

INITIATION OF EVALUATION.

PARENT/GUARDIAN NOTIFICATION OF IEP CONFERENCE.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN