EASTERN ILLINOIS AREA OF SPECIAL EDUCATION
5837 PARK DRIVE
Charleston, IL 61920
Ph: 217-348-7700 FAX: 217-348-7704

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