Kankakee Area Special Education Cooperative

P.O. Box 71 St. Anne, IL 60964 * 815-422-4151 Telephone * 815-427-8409 FAX

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):

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

_____ **Other** (Specify): _____

This information is to be released/exchanged between:

School/Agency: _____ Kankakee Area Special Education Cooperative

Address: _____ **AND** P.O. Box 71, St. Anne, IL 60964-0071

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

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