



Request for Services

Please complete this form and return it to:
Debra Quain
Kankakee Area Special Education Cooperative
1 Stuart Drive, Kankakee, IL 60901
Phone: 815-939-3651 FAX: 815-939-7236

Complete if requesting services for a student:

Student name:	Birthdate:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
District of residence:	Serving district:	School:
Teacher:	Grade/Program:	Currently receiving Spec. Ed. <input type="checkbox"/> Yes <input type="checkbox"/> No
Referral person:	Position:	Phone:
Contact person:	Position:	Phone:
Parent/Legal Guardian:		
Address:	City:	State: Zip code:
Home phone:	Work phone:	Cell phone:

****Must be accompanied by the signed Domain consent****

TYPE OF SERVICE REQUESTED

<input type="checkbox"/> Occupational Therapy evaluation	<input type="checkbox"/> Audiological evaluation
<input type="checkbox"/> Physical Therapy evaluation	<input type="checkbox"/> Behavior consultation
<input type="checkbox"/> Vision assessment (must have ocular report prior to assessment)	<input type="checkbox"/> Adapted PE assessment
<input type="checkbox"/> Hearing Impaired evaluation	<input type="checkbox"/> Other

Reason for request:

Additional comments:

Complete if requesting Professional Development:

District:	School:	Address:
Contact person:	Position:	Phone:
Topic:	Targeted date(s):	

Referring person's signature

Date

District Superintendent/Designee's signature

Date