**GENEVA COMMUNITY UNIT SCHOOL DISTRICT 304**
**OFFICE OF STUDENT SERVICES**
*227 N. Fourth Street, Geneva, Illinois 60134*
*(630)463-3060 Fax: (630)463-3069*

## PARENT REQUEST TO COMPLETE DIAGNOSTIC FORMS FOR EVALUATION

Student Name: _____ Date: _____

I _____ (parent/guardian name) am requesting the attached rating scales/forms to be completed by the following staff member/s:

| Staff Member Name: | Rating Scale Name: | Date Given to Staff Member: | Date Returned to Psychologist: |
|---|---|---|---|
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Please indicate how you would like information returned to the professional requesting the paperwork:

○ **U.S. Mail** ○ **Fax** ○ **Scan/email**

**Professional Name:** _____

**Agency:** _____

**Address:** _____

**Phone:** _____

**Fax:** _____

**Please allow 5 school days for staff to complete the paperwork and additional time if mailing. Diagnostic information will be returned directly only to the requesting professional/agency. The school will not keep a copy of the diagnostic information.**

**Parent/Guardian Signature:**_____ **Date:** _____

*For office use only:*

| Date Sent to Agency: | Signature: |
|---|---|
| | |

Revised 3/7/2018