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:

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