IRVINGTON PUBLIC SCHOOLS
SPECIAL SERVICES DEPARTMENT

Patricia Dowd, Director
Lystrea Crooks, Supervisor

1324 Springfield Avenue
Irvington, New Jersey 07111
(973) 399-6800, Ext. 1920

SPECIAL SERVICES REGISTRATION PACKET 2020-2021

PLEASE GIVE A COPY OF THE LETTER FROM SPECIAL SERVICES TO EACH REGISTERING PARENT/GUARDIAN EXPLAINING THE PROCESS.

Special Education Registration:

1. Complete District Registration Packet at student's Home School
2. Obtain copy of current IEP and evaluations
3. Complete Special Services additional forms:
   - In Transfer Permission Forms
   - In Transfer Registration Information
   - Student Emergency Form
   - In Transfer Information
   - Authorization to Release/Obtain Form
   - Notification to Principal (CST)
   - SEMI Forms (CST)

IN-TRANSFER PERMISSION FORM:

PARENT/GUARDIAN IN TRANSFER NOTIFICATION OF NEED FOR REVIEW OF CLASSIFICATION AND IEP PROCEDURES AND RIGHTS

Pupil's Name: _____

D.O.B.: _____

Assigned Program:_____

I have personally notified the parent/guardian of the above captioned child of the need for the review of his/her child's classification and IEP by the Child Study Team. I have also provided the parent/guardian with written notification of the need for review and a written explanation of procedures used and a copy of N.J. Administrative Code Procedural Safeguards Subchapter 2 and N.J.A.C. 16A.

_____

Case Manager Date

PARENT/GUARDIAN PERMISSION TO PROCEED WITH REVIEW AND RE-EVALUATION

I have received written notification of the need for the Child Study Team to review my child's classification and IEP which states the reason the review is necessary, the possible outcome of the review, mine and the school's rights regarding the review. I have also been given an explanation and description of the procedures used during and following the review of the evaluation. I have received a copy of the N.J.A.C. Chapter 28, Special Education Title 18A: Chapter 46, and N.J.A.C. Subchapter 2, Pupil Records which lists my rights regarding my child's Classification and IEP and describes procedures to be used should I choose to challenge the Individualized Educational Program developed for my child.

_____ Permission is given to conduct, review and to evaluate my child if necessary.

_____ _____ _____

Witness Date Parent/Guardian Signature

_____ Permission is given to place child in program until IEP is complete

_____ _____ _____

Witness Date Parent/Guardian Signature

IN-TRANSFER REGISTRATION INFORMATION

To be completed by Special Services Staff for In-Transfer Students registering in Special Services. This form is to be provided to the Guidance Counselor at the school in which the student will be registered.

To the Guidance Counselor:

The following information is provided to facilitate the registration of the student.

Student's Name: _____ Date of Birth: _____

Previous School: _____

Classification: _____ Current Grade Level: _____

Standardized Test Scores:

TEST NAME & SCORE:_____

Recommended Placement/Program: _____

_____

_____

Attached are photocopies of:
_____ Birth Certificate
_____ Immunization Records
_____ Proof of Residence
_____ Transfer Card
_____ Social Security Card
_____ Proof of guardianship (if applicable)
_____ Transcripts (for high school students)

***** This cover sheet verifies acceptance of the sending school's IEP. It shall be in effect for no more than 30 days

Note: High school students must have transcripts of prior credits earned for appropriate grade level placement. If parent/guardian cannot provide transcript, then they must have the previous school fax the transcript to the Special Services Department or Irvington High School Guidance Counselor.

Prepare by: _____ Team: _____ Date: _____
Child Study Team Member

_____
Return the portion to Special Services

_____ was registered in _____ school on _____ and
Has been placed according to the Child Study Team recommendation.

_____ _____
Signature of Guidance Counselor Date

STUDENT EMERGENCY INFORMATION

Date: _____

D.O.B.: _____ Grade:____

Classification: _____

Referral #: _____

Child's Name: _____

Home Address: _____

Parent/Guardian: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

List any of your child's health, physical defects, or other conditions of which the Nurse, Teacher, Driver should be aware (for example): epilepsy, convulsions, asthma, diabetes, heart conditions, wheelchair, car seat, restraints.

_____

_____

_____

List any medications which your child is taking: dosage, side effects if any, or any precautions which your doctor fells is necessary:

_____

_____

Permission to Walk: Yes: _____ No: _____

Person to be contacted in case of emergency: _____

Relationship: _____

Address: _____

Emergency Phone: _____

_____

Signature Parent/Guardian

IN-TRANSFER INFORMATION

Intake Date: _____ Team: _____ Case Manager: _____

State ID: _____ Local ID: _____

Pupil's Full Legal Name: _____
Last First Middle

Address: _____, Irvington, NJ 07111

Student is: ☐Female ☐Male D.O.B. _____ Age: _____ Grade: _____

Place of Birth: _____ State: _____ Country: _____

Parent/Guardian: _____

Relationship to Student: _____

Proof of Residency: _____ Verification: _____

Home Telephone #: _____ Cell Phone #: _____

Business/Work #: _____ Home School: _____

Student Home Language: _____

Siblings Attending Home School? ☐Yes ☐No If yes how many? _____

Classification: _____ Classification Date: _____

Previous District: _____ Previous School: _____

RACE AND ETHNICITY: (NOTE: Both Part A and B of the questions must be answered)

Part A: Is the student Spanish, Hispanic/Latino (Choose only one)

☐ No, Not Spanish, Hispanic/Latino ☐ Yes, Spanish, Hispanic/Latino

If Yes, please choose from one of the below listed Hispanic Subcategories

☐ Dominican ☐ Central and South American

☐ Cuban ☐ Mexican, Mexican American, Chicano

☐ Puerto Rican ☐ Other Spanish/Hispanic/Latino Culture or Origin _____

Part B: What is the student's race? (Choose one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander

☐ Black or African American ☐ White

Does the Student have Health Insurance: □ Yes □ No

If yes, Name of Provider: _____

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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION:

Student Name: _____
Date of Birth: _____

Address: _____

Home School: _____ Grade: _____

I, the undersigned authorize the Special Services Department of the Irvington Public Schools to Release/Obtain written records and other information to be released by:

_____
(Name and Address of Person or Agency)

_____

For the Purpose of: EDUCATIONAL PLACEMENT ☐ SCHOOL ENROLLMENT ☐

Materials to be shared or copies of records to be forwarded. (Please check)

☐ IEP – Most Recent

☐ Psychological Evaluation
☐ Learning Disability Evaluation
☐ Psychiatric Evaluation
☐ Classification
☐ Physical Therapy Report(s)
☐ Occupational Therapy Report(s)
☐ Other Consultant's Report(s)
☐ Child Study Team Summary and Educational Plan
☐ Social History
☐ Neurological Evaluation
☐ Neuropsychiatric Evaluation/Report(s)
☐ Medical Evaluation Report(s)
☐ Immunizations
☐ Attendance Record(s)
☐ Progress/Report Card
☐ Transcripts of Grades

☐ Transfer Card

_____ _____
Date Parent/Guardian Signature

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To: Building Principal

From: _____, Case Manage

Date: _____

Re: _____ D.O.B. _____

Please be advised the above named student is scheduled to begin attending your school in _____ Class. This program should begin on _____.
(Teacher's Name) (Date)

This student's program is as follows:

☐ Self-Contained
☐ Resource Center (pull out replacement)
☐ In-Class Resource
☐ In-Class Support

With the following related services:

☐ Occupational Therapy
☐ Physical Therapy
☐ Speech
☐ Transportation

If you have any questions, please feel free to contact me at _____.

Thank you.

Cc: Guidance Counselor

IRVINGTON SCHOOL DISTRICT

Our school district is participating in a system where the federal government's Medicaid will pay state and local school districts for a portion of the costs of health-related special education services provided to Medicaid eligible children. Your child will continue to receive services at no cost to you under this new system. This initiative simply helps us maximize federal funds in support of local education. The information you voluntarily provide by completing this consent form will only be used for the purposes identified.

If you have any questions, please call your child's case manager.
Please fill in the information below, sign the form, and return it to the address indicated.

CONSENT FOR RELEASE OF INFORMATION TO ACCESS MEDICAID REIMBURSEMENT FOR HEALTH RELATED SUPPORT SERVICES

Child's Name:

_____
(First) (Mid. Initial) (Last)

Child's Date of Birth: ____ ____ /____ ____ / ____ ____ ____ ____
(Month) (Date) (Year)

As parent/guardian of the child named above, I give permission to disclose information from my child's educational records to local, state, and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services in my child's Individualized Education Program (IEP).

Signature: _____ **Date:** _____
(Parent or person in parental relationship) (Month/Day/Year)

Please return this form to:

Special Services Office
1324 Springfield Avenue
Irvington, NJ 07111

IRVINGTON SCHOOL DISTRICT

Nuestro distrito escolar esta participando en un programa por el cual el gobierno federal le pagara a distritos escolares con dolares del "Medicaid" parte de los gastos de salud relacionados con la educacion especial a estudiantes elegibles para el "Medicaid". Bajo este programa, su niño continuara recibiendo estos servicios sin costo alguno a Usted. Este programa simplemente nos ayudara a aumentar los fondos federales que apoyan la educacion. La informacion que Usted proveera en esta autorizacion sera empleada solo para este proposito.

Por favor, escriba la informacion requerida, firme el formulario, y devuelvalo a la direccion indicada.

AUTORIZACION PARA REVELAR INFORMACION PARA OBTENER PAGO DEL MEDICAID PARA SERVICIOS DE SALUD

Nombre del Estudiante:

_____

(Nombre) (2do. Nombre) (Apellido)

Fecha de Nacimiento del Estudiante: ____ ____ /____ ____ /____ ____ ____ ____

(Mes) (Dia) (Año)

Como padre/tutor del estudiante aqui nombrado, doy mi permiso para revelar la informacion de los archivos escolares de mi hijo a los representantes de agencias locales, estatales, y federales con el proposito unico de obtener pago de Medicaid para los servicios de salud del Programa de Educacion Individualizado (IEP) de mi hijo.

Firma: _____ **Fecha**: _____

(Nombre y apellido de padre/tutor del estudiante) (Mes/Dia/Año)

Por favor devuelva este formulario a:

Special Services Office
1324 Springfield Avenue
Irvington, NJ 07111