LaSalle/Putnam County Educational Alliance for Special Education
1009 Boyce Memorial Drive Ottawa, IL 61350
PHONE: (815) 433-6433 FAX: (815) 433-6164

REQUEST FOR L.E.A.S.E. AUDIOLOGICAL SERVICES

Child's Name _____ Sex ____ Birthdate _____

Cell ( ) _____
Parent's Name _____ Telephone Home ( ) _____

Home Address _____ City _____ Zip _____

Parent's email address _____

Resident School District _____ County _____

School Attending _____ Telephone ( ) _____ Grade _____ Teacher _____

Describe the child's specific problem and/or behavior: _____

_____

_____

List any other agencies aware of child: _____

_____

Medicaid: _____ Yes _____ No

For Parental/Guardian Completion:

I hereby give my consent to LEASE for the above named child/student, to have audiological services as indicated above. I understand that this voluntary consent may be revoked by calling or submitting a letter for termination to L.E.A.S.E.

I understand that a copy of the audiological report will be provided to the director of special education, to the resident school district psychologist and to the resident school district nurse.

Date _____ Parent/Guardian Signature _____

_____ _____

Signature and Title of Person Requesting Audiological Email address

Return to L.E.A.S.E. at the address at the top of this form.

"Exceptional Services for Exceptional Students"