

**NOTIFICATION OF INTERVENTION AND/OR
INFORMED PARENT CONSENT FOR (RtI) DATA COLLECTION**

(Obtain prior to Tier II Movement)

Student: _____ ID: _____ DOB: _____
Grade: _____ Teacher/s: _____

This document serves as notification that my child will be provided Tier II interventions in the area/s of: _____.

I understand that the purpose of this recommendation is as follows:

- Help my child improve his/her academic/behavioral/speech or language performance based on his/her individual strengths and weaknesses.
- Provide data for monitoring the effectiveness of applied interventions.
- Provide data for determining when goals have been reached and when goals need to be changed.

Additionally, I understand that:

- This is not a referral for Special Education or Section 504. However, if tiered strategies/interventions are unsuccessful in helping my child to make adequate progress, a referral to dyslexia, Section 504, or Special Education may occur which will require a separate written consent to be signed by me for the evaluation to proceed.
- The information obtained through this process may be used as part of the eligibility determination process for Special Education.
- I will be invited to participate in each RtI Team meeting.
- I will be provided with results of decisions based on the data collected.

Parent Notification of Tier II Intervention via: Student/Phone/Mail Notified by: _____ Date: _____

Circle One

Staff Member

IF APPLICABLE, I give my consent for school staff to conduct general education evaluations regarding my child's academic performance and academic strengths and weaknesses.

Staff who may gather data about my child include:

- | | | |
|---|---|---------------------------------|
| *Classroom Teacher | *Math Specialist | *Educational Diagnostician/LSSP |
| *Bilingual/ESL Teacher | *Counselor/Social Worker | *Psychologist |
| *Curriculum Instruction Coordinator (CIC) | *Nurse/Nurse Practitioner | *Behavior Specialist |
| *Reading Specialist | *Speech Language Pathologist/
Therapist or Assistant SLP | *Autism Specialist |

The following professionals will conduct an observation of my child. Please INITIAL to indicate the following:

_____ I give my permission for the Speech Language Pathologist/Therapist to conduct an observation/screening.

_____ I give my permission for the Educational Diagnostician/Licensed Specialist in School Psychology to conduct an observation/screening.

_____ I give my permission for the Behavior Specialist to conduct an observation(s).

_____ I give my permission for the Nurse Practitioner to conduct an observation/assessment and contact my child's health care provider for further information as needed.

_____ I HAVE RECEIVED A COPY OF THE RTI PLAN TO INCLUDE INFORMATION ON STRATEGIES AND INTERVENTIONS IMPLEMENTED TO ASSIST MY CHILD.

_____ I understand the notification/information provided in this consent and my questions about this process have been answered. If I have any more questions, I can call: _____ at _____ for more information.
RtI Coordinator Campus Phone Number

- Additional data may be collected through direct observation of my child's classroom or school activities and behaviors. All data collected is confidential and will be used only for the purposes described in this consent. Results will be provided only to individuals directly involved in academic planning for my child.

THIS CONSENT IS VALID FOR ONE CALENDAR YEAR and will expire on _____ (date). I understand that I may revoke this consent at any time by submitting written notice. I understand that any observations or screening conducted prior to the withdrawal of my consent may be used by the district to address educational needs of my child.

Parent Signature

Date

Interpreter Signature

Date

Principal Signature

Date