Alabama Institute for Deaf and Blind
Deaf. Blind. Limitless.

AIDB CONSENT FOR OUTREACH SERVICES FORM

The LEA/agency requests your consent to conduct an individualized evaluation for:

STUDENT'S NAME:	**DATE OF BIRTH:**

The LEA/ agency proposed to conduct the outreach service for the following checked reasons:

☐ To determine developmental level	☐ To determine appropriate learning medium	☐ To address language inconsistent with age
☐ To determine functional level	☐ To address behavior concerns	☐ To determine current academic performance

The Outreach Service **MAY** include a review of existing information /test results and **MAY** also include evaluations/assessments in the following checked areas:

☐ Achievement	☐ Adaptive Behavior	☐ Functional Vision Assessment
☐ Intellectual	☐ Interview	☐ Orientation and Mobility Evaluation
☐ Developmental	☐ Language	☐ Learning Media Assessment
☐ Observation	☐ Speech	☐ Functional Listening Evaluation

If you give consent to an evaluation/assessment, the LEA/ agency will provide the evaluation/assessment at no cost to you. Giving consent for an evaluation/assessment does not give consent for services. If you give consent, you may revoke your consent at any time but not after the evaluation/assessment has been conducted

PLEASE CHECK ONE OF THE BOXES, SIGN, AND DATE THE FORM

☐ **I GIVE PERMISSION for the outreach service proposed**

☐ **I DO NOT GIVE PERMISSION for outreach service proposed**

☐ **I would like more information about AIDB programs or camps**

_____ **Signature of Parent of Student (Age 19)**	_____ **Date of Signature**

If you have information that can assist in the outreach service, have questions regarding this information or wish to schedule a conference, **please contact us at 256-761-3298** or email us at **outreach@aidb.org** Please email or return the form to: **AIDB Health & Clinical Services, Attention: Outreach Services Address: 205 South Street East, Talladega, AL 35160 Fax: 256-761-3860**

AIDB Alabama Institute for Deaf and Blind
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AIDB OUTREACH SERVICES
TELEPRACTICE RELEASE

Student Name: _____ **Date of Birth:** _____

I hereby consent to and authorize the use and reproduction by AIDB of any and all photographs and any other audiovisual materials taken of me and the student for assessment, observation, and educational activities.

☐ **Yes** ☐ **No**

I hereby consent to and authorize the use, sharing, transmitting, and reproduction of any and all photographs and other audiovisual material taken of me and the student between AIDB and my child's school/school district.

☐ **Yes** ☐ **No**

I understand records obtained from various sources (educational, medical, interviews, and telepractices) may be summarized into an evaluative report that will be provided to the school system and parents for the purpose of assisting with curriculum planning. I certify that the answersto the above questions are true and correct.

☐ **Yes** ☐ **No**

PARENTAL/GUARDIAN CONSENT

I certify that I am the parent or guardian of the individual above, a minor under theage of eighteen years. I hereby agree to assume legal responsibility for his/her authorizations referred to in this release.

Signature of Parent/ Guardian _____ **Date** _____

Street Address of Parent/ Guardian _____ **City** _____ **State** AL **Zip Code** _____

Parent/Guardian Phone Number _____

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APPLICATION FOR OUTREACH SERVICES

INFORMATION RELATED TO CHILD:

1. Name _____
LAST FIRST MIDDLE

2. Preferred Name _____

3. Sex _____ 4. Birth Date _____ 5. Race _____ 6. Grade _____

7. Parent's Name _____

8. Address_____ **AL** _____
STREET CITY STATE COUNTY ZIP

9. Parent's Phone Numbers: Home Number: _____

Work Number:_____ Cell Number:_____

10. Parent's Email Address: _____

11. Person/agency referring child: _____Contact Number:_____

12. How does the child communicate? Orally___Manually___ Both ___ ESL___

13. What is the child's native language:_____

APPLICANT'S HISTORY OF SCHOOL ATTENDANCE

1. Name of school now attending _____ Date Admitted _____

Address

_____ **AL** _____
STREET CITY STATE ZIP

2. Type of program: (Indicate if full-time; if part-time, indicate number of hours per week)

_____

INFORMATION RELATED TO HEARING LOSS AND/OR VISION LOSS:

Vision Loss-Please complete if your child has been diagnosed with a visual impairment

1. Does the child have a **vision loss**? Yes ☐ No ☐

2. If yes, at what age was the **vision loss diagnosed**? _____

3. Cause of **visual impairment** if known: _____

4. Has the child been examined by an ophthalmologist (M.D.)? _____

5. Who performed the examination? _____

6. When was the last examination? _____

7. **Vision diagnosis**: _____

8. Have any **operations** been performed **on the eyes**? Yes ☐ No ☐

(a) What kind? _____ (b) By Whom? _____

(c) Where? _____ (d) Date _____

9. Does the **child wear glasses**? _____

Hearing Loss- Please complete If you child has been diagnosed with a hearing loss:

1. Does the child have a **hearing loss**? Yes ☐ No ☐

2. If yes, at what age did **hearing loss diagnosed**? _____

3. Cause of **hearing loss**, if known: _____

4. Date of last **hearing test**: _____ Where?_____

5. Have any **operations** been performed **on the ears**? Yes ☐ No ☐

(a) What kind? _____ (b) By Whom? _____

(c) Where? _____ (d) Date _____

6. Does child use a **hearing aid**? ___ At what age did the child first wear aid? _____

7. Does the child have a **cochlear implant**? _____ **Year implanted**:_____

8. Does the child have a **bone anchored hearing aid (BAHA)**?____ **Year implanted ____**

ADDITIONAL DISABILITIES _____

_____

I ***understand*** records obtained from various sources (educational and medical) may be summarized into an evaluative report that will be provided to the school system and parents for the purpose of assisting with curriculum planning. I ***certify*** that the answers to the above questions are true and correct.

To enable the capability of access to additional resources, this information may be shared with AIDB Regional Centers.

Date: _____ SIGNED: _____
Parent or Legal Guardian

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AIDB OUTREACH SERVICES
REQUEST FOR INFORMATION
EDUCATIONAL and MEDICAL RECORDS

This form is used when parents are giving their permission for an organization, an agency, or an individual to send information about their child to the Alabama Institute for Deaf and Blind.

Date _____

I,_____ the parent or guardian of the child whose name is listed on this form, request that the school send the information requested regarding my child to the Alabama Institute for Deaf and Blind.

School System: _____

Name of school: _____

Address: _____

_____

City State ZIP

Telephone: _____

Name of Child _____ Date of Birth _____

School student is now attending or has attended: _____

Please forward a copy of the following records: Cumulative record, most current IEP, Eligibility Decision Regarding Special Education Services report, evaluations (psychological, educational, behavioral/adaptive behavior, vision, audiological, speech, physical therapy, occupational therapy, intellectual and achievement scores).

Please send information to:
AIDB Health & Clinical Services Attn: Outreach
P. O. Box 698
Talladega, AL 35161
Fax: 256-761-3860 Email: outreach@aidb.org

Parent/Guardian Signature: _____

Address: _____ AL _____

Telephone: _____

Alabama Institute for the Deaf and Blind
Alabama Instructional Resource Center for the Blind

Dear Parents and Guardians,

The purpose of this letter is to inform you that the Alabama Instructional Resource Center for the Blind is in the process of completing the Annual Federal Quota Registration of Blind Students through the American Printing House (APH) Federal Quota Program. This federally funded program provides textbooks, educational aids, and other learning materials for qualifying children with visual impairment and blindness.

In order to be included in the Federal Quota program, eligible students must be registered in an annual census, requiring the exchange of specific personally identifiable student information (PII). This information is only collected to meet the reporting obligations to the U.S. Department of Education Office of Special Education Programs, and other entities as required by law.

The Family Educational Rights and Privacy Act (FERPA) requires your written consent to release your child's personally identifiable information to APH for these purposes. If you consent, the names(s) of your child(ren) will be registered, along with other pertinent information including birthday, school district, grade placement, primary reading medium, and indication of visual function. All PII collected for this registration is private and will be protected from unauthorized access or use. Your child's PII will not be shared with any other entities or for any other purpose, unless permitted by state or federal law.

Consent to include your child in the Federal Quota Census allows the Alabama Instructional Resource Center for the Blind to purchase products and materials from the APH on behalf of your child and other children in our state. You may choose not to provide your consent; however, doing so will mean that fewer Quota funds will be provided to Alabama.

The Federal Quota Census Registration is completed under the supervision of the Ex Officio Trustee (EOT) designated to oversee his or her respective APH accounts. It is the responsibility of the EOT to submit accurate information to APH in a secure manner. If you have questions or concerns regarding the Annual Federal Quota Registration Process, please contact your EOT, Caitlin Cox at cox.caitlin@aidb.org .

Alabama Institute for the Deaf and Blind
Alabama Instructional Resource Center for the Blind

Consent to Release Student Information

In order to register my child with the Alabama Instructional Resource Center for the Blind (AIRCB) and the American Printing House for the Blind (APH), I hereby authorize _____ (the local school district) to share my child's personally identifiable information as follows: First, Middle, and Last name, Date of Birth, School District, Grade Placement, Visual Function, Primary and Secondary Reading Medium, and cross reference of siblings also registered (to prevent duplication of registration) with the following:

- Designated Regional APH Census Representative (Teacher of the Blind and Visually Impaired)
- Alabama Institute for the Deaf and Blind/Alabama Instructional Resource Center for the Blind
- American Printing House for the Blind

I, _____ (print name), certify that I am the parent(s)/guardian(s) of _____(students full name), whose date of birth is _____ (student's complete date of birth), and that she/he is a dependent according to Section 152 of the Internal Revenue Code if she/he is over eighteen years of age. I understand that this release will remain in effect unless I revoke it in writing. I further understand that I can revoke this release at any time by sending an email to Caitlin Cox at cox.caitlin@aidb.org .

_____ _____

Signature Date