

# ATECH Vision & Hearing Services



117 Pleasant St., Dolloff Building, Concord, NH 03301

[www.atechvh.org](http://www.atechvh.org)

tel: 603.226.2900 fax: 603.226.2907



## Request for Services: SY 2009-2010

Form must be completed *in its entirety*.

Date submitted: \_\_\_\_\_ Request for Consult/Training

### STUDENT INFORMATION

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade in SY 09/10: \_\_\_\_\_ SASID # (REQUIRED) \_\_\_\_\_

### SCHOOL INFORMATION

School (09-10) \_\_\_\_\_

School address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Responsible SAU # \_\_\_\_\_ SAU Contact \_\_\_\_\_ Phone \_\_\_\_\_

### PARENT INFORMATION

PARENT/GUARDIAN 1:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

PARENT/GUARDIAN 2: (IF ADDRESS IS DIFFERENT)

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

### SPECIAL EDUCATION STATUS

Check here if this is a special education student. List ALL special education identifications on student's IEP

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Student has a 504 plan.  Student is in the process of determination

**RELATED RESOURCES**

- Student has services of a Teacher of Students with Visual Impairments
- Student has services of a Teacher of Students who are Deaf or Hard of Hearing

Teacher's name \_\_\_\_\_



**SENSORY IMPAIRMENTS**

Please provide us with information regarding this student's sensory impairment by checking ALL relevant boxes below and by attaching relevant reports to document the sensory impairment.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hard of Hearing       | <input type="checkbox"/> Unilateral Hearing Loss      | <input type="checkbox"/> Central Auditory Processing Disorder    |
| <input type="checkbox"/> Deaf                  | <input type="checkbox"/> Auditory Neuropathy Spectrum | <input type="checkbox"/> Uses FM System                          |
| <input type="checkbox"/> Uses Cochlear Implant | <input type="checkbox"/> Uses Hearing Aids            | <input type="checkbox"/> Uses CART/CPrint in the classroom       |
| <input type="checkbox"/> Oral Communicator     | <input type="checkbox"/> Uses Sign Language           | <input type="checkbox"/> Uses Sign Language Interpreter Services |
| <input type="checkbox"/> Low Vision            | <input type="checkbox"/> Blind                        | <input type="checkbox"/> Cortical Visual Impairment              |
| <input type="checkbox"/> Large Print User      | <input type="checkbox"/> Braille User                 | <input type="checkbox"/> Pre-reader                              |
| <input type="checkbox"/> Deafblind             | <input type="checkbox"/> Has Additional Disabilities  |  |

***Upon receipt of this request, a consultant will contact the school to discuss this student's needs. Please indicate the person at the school you would like us to contact, and the best way to make that contact.***

School contact \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email \_\_\_\_\_

Best way to contact:  Email  Work Phone Best time to call: \_\_\_\_\_

*The district requests contact from an ATECH Vision & Hearing Services consultant to plan for educational services for this student.*

\_\_\_\_\_  
School District Signature Date

**PARENTAL PERMISSION**

*I hereby grant permission for the school district to request services from ATECH Vision/Hearing Services and to exchange information with ATECH Vision/ Hearing Services necessary to plan for and provide appropriate services.*

\_\_\_\_\_  
Parent/Guardian Signature Date