EXCEPTIONAL STUDENT DEPARTMENT

Parental Consent for Placement

Exceptional Student Transferring from Another District

Name of Student: _____ Date of Birth: _____

Legal First Name Last Name

The Thomas County School System will implement the service and placement options in the most current IEP developed at the previous school system. IEP must be received in order to implement. **

_____ _____

School Name IEP Implementation Date

I understand that this recommendation includes all the service needs identified in my child's Individual Education Program (IEP).

_____ Yes, I do agree with this statement.

_____ No, I do not agree with this placement for the following reason(s):

_____

_____

_____ I would like a conference concerning my child's placement.

Signature of Parent or Legal Guardian: _____

Contact Numbers for Legal Guardian: _____

Date: _____

*The Director of Exceptional Students will review your child's current IEP and Eligibility and determine if additional evaluation or information is needed to serve your child. If so, you will be contacted by your child's case manager for required consent forms and information.

**If your child's IEP or eligibility is expired, you will be contacted immediately.

Carol Sprague, Director of Exceptional Students
Phone: 229-225-4380

EXCEPTIONAL STUDENTS DEPARTMENT

Parental / Guardian Consent Form For Medicaid and/or Peachcare

Name of Student: _____ Date of Birth: _____
Last Name Legal First Name

SS#: _____ Parent/Guardian: _____ Relationship to Child: _____
Student's Social Security Number

Street Address: _____

City: _____ State: _____ Zip: _____

Dr. Name (Student's Physician): _____

Dr. Phone Number: _____

Dr. Address: _____ City: _____

Reimbursement for services does require that your child's physician complete a form. Once you provide the contact information requested on this consent form, a document will be sent to the physician for completion. Your selection and signature gives or denies your permission for Thomas County Schools to provide pertinent information pertaining to services provided in the student's IEP to their physician as required by Medicaid.
Thomas County Schools is providing the health-related services to your child in accordance with his/her Individual Education Program or Service Plan. Medicaid and/or PeachCare is required to cover some of the cost of certain services.
Thomas County Schools cannot bill Medicaid/PeachCare without your consent. If you allow the school system to bill Medicaid or PeachCare for the health-related services that your child is receiving in accordance with his/her Individual Education Program or Service Plan, check the "Yes" box and sign below.

☐ **YES** I authorize the School System to bill Medicaid and/or PeachCare for the health related services listed in my child's IEP or SP.

☐ **NO** I do not want Medicaid and/or PeachCare billed for health related services my child is receiving.

☐ My child does not currently receive Medicaid, however, if they do in the future, I give THOMAS COUNTY SCHOOLS permission to bill for services.

◊ CONSENT TO BILL MEDICAID ◊

During the COVID-19 medical emergency, the school system may utilize Telemedicine/Teletherapy to deliver services to your student for any services/therapies in their IEP/SP. Important points to consider:

- During the teletherapy session details of your child's therapy and/or services provided will be discussed through the use of interactive video, audio, and telecommunication technology. Video, audio and/or photo recordings may be taken of your child during the service(s).
- Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the teletherapy session, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during the teletherapy sessions.
- You have been advised of all the potential risks, consequences and benefits of teletherapy. Your school-based therapist has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the teletherapy sessions. All your questions have been answered, and you understand the written information provided above.

☐ **YES** I agree to participate in teletherapy for the purpose of evaluating and/or delivery of my child's services in their IEP or SP. *I agree to maintain the privacy of my child's sessions and, in the case of group therapy sessions, the privacy of other students' therapy and information that I may gain during the process.*

☐ **NO** I do not agree to participate in teletherapy.

◊ CONSENT FOR TELETHERAPY ◊

Parent/Guardian Signature: _____

Date: _____

It is my responsibility as a parent to notify Thomas County Schools Exceptional Students Department in writing if I ever decide to withdraw this consent allowing the school to seek reimbursement from Medicaid/PeachCare.

NOTE: As of April 1, 2003, the Children Intervention Services Program (CIS) and the Children Intervention Schools Service Program (CISS) have been separated. Students can receive medical services in both programs without impacting service limitations.

If you have any questions, please call: Carol Sprague, Director of Exceptional Students (229-225-4380)

EXCEPTIONAL STUDENTS DEPARTMENT

Authorization for Release of Information

By signing below,

Parent/guardian signature: _____ Date: _____

I authorize verbal and/or written information to be exchanged, regarding:

Student's name: _____ Date of Birth: _____

for purposes of consultation and educational planning, between

	Primary Requestor:	AND	Secondary Requestor:
School	Thomas County Schools		_____
Requestor	Carol Sprague, Director		_____
Street Address:	200 North Pinetree Blvd.		_____
City, State, Zip:	Thomasville, GA 31792		_____
Phone:	229-225-4380		_____
Fax:	229-225-5234		_____
Email:	erodriguez@tcjackets.net		_____

and

Name: _____ Fax: _____

Address: _____ City: _____ State: _____

Name: _____ Fax: _____

Address: _____ City: _____ State: _____

Name: _____ Fax: _____

Address: _____ City: _____ State: _____

Each of these sites may require you to complete their HIPPA form as well.

The following information may include:

_____ Individual Education Plan, Eligibility Report , Recent Redetermination tied to previous eligibility report, Psychological Report(s), Educational Reports , 504 Plan

_____ Medical Reports, Psychological Testing, Psychiatric Reports, Social Reports

_____ Other _____ _____ Please exit the student from GO-IEP

The above information will be used for the following purposes:

_____ Placement _____ Evaluation _____ Other: _____

I understand that I may revoke this consent at any time by providing written notice and will hold all agencies harmless for information released prior to written revocation. After one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

EXCEPTIONAL STUDENT DEPARTMENT

Transfer Information

Exception Student Transferring from Another District

_____
Date

Name of Student: _____ Date of Birth: _____
Legal First Name **Last Name**

Student Grade: _____

Special Education services provided by : _____
County/School District and Phone Number

_____
Name and Address of Previous School Contact Person Phone Number

I agree that the services are specified on the transfer information are correct. I understand this information will be utilized by Thomas County Schools as my child's educational plan. If changes need to be made to better meet my child's needs, I will be notified.

_____ _____
Parent/Guardian Signature Date

Completed by Exceptional Student Department

IEP: _____ Redetermination: _____ Eligibility: _____

Last Psychological: _____ Transfer Re-Eval. data review (60 day!): _____

Entered GO-IEP: _____ Case Manager Assigned: _____ Eligibility date Correct: _____

Special Information: _____

Parent Requesting a Conference: _____

In General Ed. Setting

Services: _____ Services: _____
Services: _____ Services: _____

In Special Ed. Setting

Services: _____ Services: _____
Services: _____ Services: _____

Related Services

Services: _____ Services: _____
Services: _____ Services: _____
OT/PT: _____ Special Transportation: _____
State Testing: Milestones GAA

Approved: _____ _____
Signature of the Director of Exceptional Student Date

Individuals to be notified of acceptance:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

PLEASE PICK-UP THIS STUDENT AS SOON AS POSSIBLE FOR THE SERVICES SPECIFIED.

Rev: 2020 May

EXCEPTIONAL STUDENT DEPARTMENT

Student Information

Exceptional Student Transferring from Another District

Date: _____

Name of Student: _____ Date of Birth: _____
First Last

Grade: _____ Gender: _____ Race: _____

Physical Address: _____

_____

Mailing Address (if different): _____

_____

Home phone number: _____ Work phone number: _____

Emergency Contact Person: _____ Phone number: _____

Doctor: _____ Phone number: _____

List any allergies or medical problems: _____

_____

List any medications your child takes: _____

_____

List any brothers and sisters enrolled in the Thomas County School System:

NAME	AGE	GRADE	SCHOOL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____