INDIANA SCHOOL FOR THE BLIND AND VISUALLY IMPAIRED

Outreach and Related Services

7725 N. College Avenue

Indianapolis, IN 46240

Phone: (317) 253-1481 Fax: (317) 259-4945

**REQUEST FOR ISBVI SERVICES**

LOCAL EDUCATIONAL AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIAL EDUCATION DIRECTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGENCY ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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AGENCY PHONE/FAX NUMBERS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the specific ISBVI services you are requesting:

(**There is a $125.00 charge/hour portal to portal for an FVA/FLA, MAT Lab, O&M eval, or observation)**

**(If requesting two services at the same time, there will only be one $125.00 charge per hour portal to portal as long as there is only one trip to complete the request.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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LEA – Director of Special Education or Program supervisor (Signature) Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher of Students with Visual Impairment (Signature) Date Signed

Teacher of Students with Visual Impairment Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature below indicates consent for participation of ISBVI representative(s) in the services specified above and permission for release/exchange of medical and educational information specific to requested services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (Signature) Date Signed

Parent/Guardian Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date request received \_\_\_\_\_\_\_\_\_\_\_\_

 Date of contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date report completed \_\_\_\_\_\_\_\_\_\_

 Date report sent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date report completed \_\_\_\_\_\_\_\_\_\_\_

 Date report sent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please attach a current copy of the IEP and FVA/FMA**.