PARENT PERMISSION TO OBTAIN AND RELEASE INFORMATION OUTSIDE AGENCIES

Date: _____

Student Name: _____
Last First MI

Address: _____
Street/PO Box City State Zip Code Home Telephone #

Tribal Information: _____
Tribal Affiliation Tribal Enrollment #

I, the undersigned, hereby request and authorize:

AND

Ho-Chunk Nation Disabilities Program
Attn.: Cheryl Funmaker
P.O. Box 667
Black River Falls, WI 54615

School District Name: _____
Office: _____
Street Address: _____
City, State, Zip: _____

To exchange requested information pertaining to the student named above which has been indicated below:

- Official Student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)
- Medical and/or related health records
- Psychological evaluations or social work reports
- Individualized education team evaluations and related reports
- Appropriate agency reports
- Individualized education program (IEP)
- Other (specify): _____

This permission is valid for one year from the date signed. A copy of this form is as effective as the original.

Parent / Guardian

Signature: _____ Date: _____

NOTE: Ho-Chunk Nation Department of Education reserves the right to information gathered during this period.

HCN Education Department
Phone: (715)284-4915 * Fax: (715) 284-1760 * Email: Education.Intake@Ho-Chunk.com

Ho-Chunk Nation Education Department
Disabilities Division
Intake Form

Parent/Guardian Name:_____

Address:_____

Phone:_____Email:_____

School District:_____Student Grade:_____

Reason for Inquiry (check all that apply):

Academic Support_____
Assessment _____
Attend IEP_____
Bullying_____
Change of Placement_____
Comprehensive Services ____
Disability Code Request_____
Discipline_____
Grades_____
Higher Education_____
IEP Questions _____
Mental Health _____
Parent Support _____
Parent Training _____
Resources/Programs _____
Therapeutic Services _____
Vocational Rehab_____
504/Individual Health Plan_____

W9814 Airport Rd.
P.O. Box 667
Black River Falls WI 54615
PH: (800)362-4476
FAX: (715)284-1760
Education.Intake@Ho-Chunk.com

Ho-Chunk Nation Education Department
Disabilities Division

Release of Information consent within Education Department

Student Name_____D.O.B._____

Street Address _____

City/State/Zip Code: _____

Records Requested From _____

TYPE OF RECORDS REQUESTED:

_____Consent to communicate to Ho-Chunk Nation Disabilities Division regarding student academic, assessment, disciplinary, and special education records through the end of 20___School Year.

PURPOSE:

1) To assist student & parents in the development of the IEP.
2) To assist student & parents in advocacy.
3) To assist student & parents in Pre-K special education requests.
4) To assist student & parents in transitioning to Higher Education.

DISCLOSURE OF RECORDS WILL REMAIN WITHIN:

Ho-Chunk Nation Education Department

I understand that my records are protected under the CFR25, Part 43, 1-23 and cannot be disclosed without my written consent, other than the above mentioned. Any re-release of these records will result in immediate revocation. I also understand that I may revoke this consent at any time, except to the extent that the action has been taken in reliance on it and that in any event, this consent expires automatically within twelve (12) months from this date.

_____ _____

Student Signature **Date**

_____ _____

Parent Signature **Date**

Education Department Disabilities Division
PO Box 667
Black River Falls, WI 54615
(PH) 715-284-4915
Fax: 715-284-1760
Education.Intake@Ho-Chunk.com