

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

**PROTECTED HANDICAPPED STUDENTS
RESPONSE TO REFERRAL**

Parent/Guardian
Address

Date _____

Re: Name of Student _____

Student ID _____ **Date of Birth** _____

Dear Parent/Guardian:

The School Support Team at _____ School
has reviewed your child's records and concluded that your child: (*check one*)

- should be identified as a protected handicapped student as indicated below.
- should not be identified as a protected handicapped student as indicated below.
- requires a change or modification of the current service agreement as indicated below.
- should no longer be identified as a protected handicapped student as indicated below.

Reason/Explanation:

You have the following rights:

- To review your child's education records
- To discuss your child's education records with someone who is authorized to answer your questions
- To discuss the referral and proposed evaluation plan with a member of the school support team
- To give or withhold consent for all or part of the proposed evaluation plan
- To request a hearing about all or part of the proposed evaluation plan.

You can arrange to do any of the above by calling _____

Sincerely,

Case Manager _____