



# CROTCHED MOUNTAIN ATECH Services



57 Regional Drive, Suite 7, Concord, NH 03301  
tel: 603.226.2900 fax: 603.226.2907

## Request for Vision & Hearing Services: SY 2012-2013

Please complete this form in its entirety.

Date submitted: \_\_\_\_\_

### STUDENT INFORMATION

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade in SY 2012/13: \_\_\_\_\_ SASID # (REQUIRED) \_\_\_\_\_

### SCHOOL INFORMATION

School (12-13) \_\_\_\_\_ Responsible SAU # \_\_\_\_\_

School Address \_\_\_\_\_

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

### PARENT INFORMATION

PARENT(S)/GUARDIAN 1:

Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

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

PARENT(S)/GUARDIAN 2: (IF ADDRESS IS DIFFERENT)

Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

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

### 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

**STAFF**

- Student's IEP or 504 plan includes a Teacher of Students with Visual Impairments and/or a Teacher of Students who are Deaf or Hard of Hearing



Teachers' name(s)/Agency: \_\_\_\_\_

**SENSORY IMPAIRMENT(S)**

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

- |  |   |  |
|--|---|--|
| <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 Aid(s)                          | <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 (describe) _____ |  |

***Please mail or fax this request for services to Lisa Demers at ATECH. If this is a student new to ATECH, please attach the student's current IEP or 504 Plan and the most recent vision and/or hearing evaluations. 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.***

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

Work phone \_\_\_\_\_ Email \_\_\_\_\_

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

|                      |                |       |
|----------------------|----------------|-------|
| _____                | (Printed Name) | _____ |
| Authorized 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  |