# Dekalb Pediatric Center

Jane Wilkov, MD, Debby Pollack, MD, Michal Loventhal, MD,
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Mary Abraham, MD & Lesley Cogburn, RN, CPNP
350 Winn Way
Decatur, GA 30030
(404) 508-1177

**Date _____**

**Student's Name: _____**

**Student's Date of Birth: _____**

**School Attending: _____**

**Grade Level: _____**

Dear Teacher:

This student is being evaluated for school and behavioral problems. Before this comprehensive evaluation can be completed, we need your input. Please be as honest as possible with your response - your comments and information are an important part of the evaluation and will be combined with other sources of information before a conclusion is reached about this child's behavioral health issues.

We are hoping to complete the evaluation within the next 2-3 weeks. It would be most helpful if you could return the forms in the following packet within the next 1-2 weeks. Please return the completed the forms by mailing them to our office in the self addressed stamped envelope included in this packet or faxing them to our office at the number provided above.

In addition, we need information about any psycho-educational testing this child my have received or any formalized plans the school may have put into place to address his/her behavioral/educational needs. Please include copies of any formal test results and/or plans (e.g., IEP plan).

Enclosed is a signed parent consent form to demonstrate the parent's hope that you will share this information with us.

If you have any questions please contact us at DeKalb Pediatric Center, 404-508-1177.

Thank you for your time and input.


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# RELEASE OF SCHOOL RECORDS

Name of Student:_____

Child's Date of Birth: _____

School District: _____

I give my consent for the school district named above to release the following information about school behavior and performance (including school academic records) and school services (including special education placement, results from psycho-educational testing, or other school services) to the pediatricians who provides services at

**DeKalb Pediatric Center, PC**

Legal guardian: Please complete all of the following information:

_____ X _____

**Date** **Signature of legal guardian**

_____
Printed name of legal guardian

_____
Relationship to Child

_____
Child's social security number or ID

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## PARENT CONSENT FOR DIRECT SCHOOL-PEDIATRICIAN COMMUNICATION

_____

Child's Name (Please Print)

_____

Child's Date of Birth

I hereby consent to and authorize my child's **20___-20___ teacher(s), school nurse, school counselor, school psychologist, and/or principal** and the pediatricians in the practice of DeKalb Pediatric Center, PC, to share information directly with each other about my child's grades, achievement test scores, academic performance, psycho-educational test results, behaviors, academic interventions and treatments (if any). This information will be shared in order to better care for and manage my child's school behaviors.

Legal guardian: Please complete all of the following information:

Date_____ x_____
Signature of legal guardian

_____
Printed name of legal guardian

_____
Relationship to child

_____
Social Security # or ID for child