Hawai'i & Pacific Deaf-Blind Project

REQUEST FOR SERVICES

Please return the completed form to:
Hawai'i & Pacific Deaf-Blind Project
ATTN: Jennifer Tarnay
1410 Lower Campus Road 171F
Honolulu, Hawai'i 96822
Fax: 808.956.7878

Note: To be completed by the student's educational team for any referral made to the Hawai'i & Pacific Deaf-Blind Project

Date: _____

Personal Info

Student's Name: _____
Date of Birth: _____/_____/_____ Age: _____ Sex: F M
Parent(s)/Guardian(s) Names: _____
_____
Address: _____
_____
Home Phone: _____Cell Phone: _____

Primary Etiology/Diagnosis: _____
Other Disabilities: _____

Educational Placement

School _____ Home _____ Other (please specify) _____
If school based, please complete below
School Name: _____
School Address: _____
_____
School Telephone: _____ School Fax: _____
Grade Level: _____

If the student is 16 years or older:
Is there a Transition Plan (ITP): yes _____ no _____
Special Education Administrator: _____
Care Coordinator/Primary Contact Person: _____
Care Coordinator/Primary Contact Person's Telephone: _____
Care Coordinator/Primary Contact Person's Email: _____

Local Team Serving Student

Principal/Administrator: _____
Telephone: _____ Email: _____

Special Education Teacher: _____
Telephone: _____ Email: _____

General Education Teacher: _____
Telephone: _____ Email: _____

Educational Assistant/1:1: _____
Telephone: _____ Email: _____

Speech Language Pathologist: _____
Telephone: _____ Email: _____

Occupational Therapist: _____
Telephone: _____ Email: _____

Physical Therapist: _____
Telephone: _____ Email: _____

VI Teacher/Consultant: _____
Telephone: _____ Email: _____

HI Teacher/Consultant: _____
Telephone: _____ Email: _____

O & M Teacher/Consultant: _____
Telephone: _____ Email: _____

Social Worker: _____
Telephone: _____ Email: _____

Nurse: _____
Telephone: _____ Email: _____

Psychologist: _____
Telephone: _____ Email: _____

DVR Counselor: _____
Telephone: _____ Email: _____

DOH Personnel: _____
Telephone: _____ Email: _____

Other: _____ Title: _____
Telephone: _____ Email: _____

Other: _____ Title: _____
Telephone: _____ Email: _____
The Hawai'i-Pacific Deaf-Blind Project may assist with: Person Centered Planning, Circles of Friends, IEP/IFSP development and implementation, adapting curriculum and environments, related services/equipment, transition planning, interagency/team collaboration, family support, etc.

Please indicate specifically what assistance is being requested from the Project.

1. _____
   _____
2. _____
   _____
3. _____
   _____

Signatures (Please sign before returning)

_____ _____
Administrator Date

_____ _____
Team Representative/Position Date

FAMILY PERMISSION

I give permission for _____'s (child's name) educational team to consult with members of the Hawai'i- Pacific Deaf-Blind Project regarding his/her educational program for the school year. The Hawai'i-Pacific Deaf-Blind Project, staff has permission to access my child's educational file, to conduct needs and skills assessments, and to share information on my child with each other in order to provide this assistance.

I understand that strict confidentiality will be observed in the use of all information. I also understand that this consultation is a free service.

Date _____ Parent/Guardian Signature_____

PHOTO CONSENTS

I grant permission to the staff of the Hawai'i-Pacific Deaf-Blind Project, Center on Disability Studies, University of Hawai'i to: (please check all that apply)

□ take photographs and videotape recordings of my child(ren), myself and my spouse for the purposes of assessment, data collection and information-sharing among my child's educational team members;

□ use photographs and videotape recordings of my child(ren), myself and my spouse for the purposes of documentation, dissemination and training. I understand that these photographs or video clips may be published in a brochure, Power Point presentation, Web-based format, or newsletter for the Hawai'i-Pacific Deaf-Blind Project.

Date_____ Parent/Guardian Signature
_____