Student Name:

Grade:

Date of Birth:

Albert Lea High School

Date:

**Review Parents Rights Brochure with parents/guardians at each IEP meeting.**

**Ask parents to initial for each statement and sign/ date this form.**

\_\_\_\_\_ The Parent’s Rights and Procedural Safeguards notice has been offered to me.

\_\_\_\_ The Parent’s Rights and Procedural Safeguards notice has been explained to me.

\_\_\_\_\_ If your child receives nursing or personal care assistant services at school, we must obtain  
 medical orders from your child's doctor or clinic. We need to tell the doctor or clinic  
 your child's name, date of birth, why your child needs services, and the type(s) of health  
 services your child receives during school hours. We need your consent each year to  
 share data to receive medical orders. Please initial here if you agree to allow us to share   
 data and get orders for nursing and/or personal care assistant services.

\_\_\_\_\_ I do not want the district to ask my private health plan if IEP health related services are  
covered for my child. I understand that this will not affect the educational services that  
he/ she receives in school.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parent Signature Date

Attach this form to the back of the Individual Education Plan or Evaluation Report.