**PERMISSION FOR MULTI-TIERED SYSTEM OF SUPPORT (MTSS) SCREENING**

**Services Requested: ( )** Occupational Therapy **( )** Physical Therapy **( )** Speech & Language

 Pathologist

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission for the school district and its related services or

Parent/Legal Guardian

Alternate staff to provide screenings or interventions to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Name of Student

This consent is valid for the 2023-2024 school year.

I understand that giving consent and permission to MTSS screening and/or intervention may include the services of a licensed occupational therapy provider, licensed physical therapy provider, or licensed speech and language pathologist. This may include observing the child in their educational setting, reviewing written information, and/or administering screening tools to determine level of functioning and need for further evaluation.

I further understand and agree that any information collected by the licensed therapy provider, school district, or other staff will be reviewed by support staff, my child’s teacher(s), and MTSS team as applicable. If strategies and/or interventions are recommended to improve classroom performance, they will be implemented by the related service provider and/or classroom staff for a timeframe determined by the provider, classroom staff, and school district. I understand that my child may receive support or intervention services within their educational environment, including areas outside of the general education classroom.

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Name of Parent or Legal Guardian (Please print)

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Signature Date

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Name of Teacher(s) (Please print)

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Signature Date

Therapy Provider (Please print) Signature Date