EMANUEL COUNTY SCHOOLS
A Tradition of Excellence

P.O. Box 130
Swainsboro, GA 30401
478-237-6674
Fax: 478-419-1102

REQUEST FOR EXCEPTIONAL STUDENT RECORDS

I hereby authorize: _____(former school name)
_____(address)
_____(city, state, zip)
_____(phone/fax number)

To release confidential records for:

Student name: _____
Date of birth: _____Grade: _____

Release to: **Emanuel County Program for Exceptional Children**
Attn: Tracy Williams, Secretary for Student Services
P. O. Box 130
Swainsboro, GA 30401
Phone: 478-419-1104
Fax: 478-419-1102

Records to be released:
***Due to GA DOE student data guidelines, please include the current and initial copies of these items**

_____**IEP***/Annual Review _____ **Eligibility***/Re-evaluation Report(s)
_____Psychological Reports _____ Hearing and Vision Screenings
_____Parental Consent for Placement _____SST documentation
_____Parental Consent for Evaluation _____Medical Review/Information
_____Other: _____

This is to certify that I approve the release of records to the Emanuel County Program for Exceptional Students. I understand that my child will be served in the _____ program, as recommended by the placement team from the previous school. Once the IEP records are received, an IEP meeting will be scheduled within 30 days to review IEP services and placement options. I have received a copy of parent's rights from Emanuel County.

____ Yes, I agree with the placement. _____ No, I do not agree with the placement.

_____ _____

Parent Signature/ Date **PEC Representative/Date**