Providing the Finest Quality Special Education in a Jewish Day School Setting

RELEASE OF INFORMATION

Dear Families

In order to complete the application process, it is necessary for Kesher to gain a thorough understanding of your child's current performance and needs. For this reason, an observation in your child's current school is a mandatory step. If this is not possible alternative observation arrangements can be made. Additionally we will need to contact any other professionals who support your child outside of school. The information gained through this process will not only allow for an informed decision about acceptance into Kesher, but also provide us with the tools needed to create the ideal programming to meet your child's needs. Kesher's team approach to education begins here.

PLEASE FILL IN THE INFORMATION REQUESTED ON BOTH SIDES

If your child has been in his/her school for less than 2 years, please include the previous school below.

Student’s Name: _____

☐ I give permission to Kesher L.D., Inc. to contact the following school and have a Kesher professional observe my child in his/her current classroom.

☐ I have contacted my child’s current school and have given the school permission to allow a Kesher professional to observe my child in his/her current environment.

Parent/Guardian Signature: _____ Date:_____

☐ **CURRENT SCHOOL**

Name of School: _____

Address:_____

Contact Person: _____

Phone: _____ Fax:_____Email:_____

☐ **PREVIOUS SCHOOL**

Name of School: _____

Address:_____

Contact Person: _____

Phone: _____ Fax:_____Email:_____

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KESHER L.D., INC.
Michael-Ann Russell JCC • Sanford L. Ziff Campus • 18900 NE 25th Avenue • North Miami Beach, FL 33180
Phone (305) 792-7060 • Fax (305) 792-7018 • admissions@kesherld.org • **www.kwkacademy.com**

☐ I give permission to Kesher L.D., Inc. to contact and share information with the following professionals.

Parent/Guardian Signature: _____ Date: _____

☐ **SPEECH THERAPY**

Therapist Name/Company: _____

Phone: _____ Fax: _____ Email: _____

☐ **OCCUPATIONAL THERAPY**

Therapist Name/Company: _____

Phone: _____ Fax: _____ Email: _____

☐ **PHYSICAL THERAPY**

Therapist Name/Company: _____

Phone: _____ Fax: _____ Email: _____

☐ **ABA PROGRAMMING**

Therapist Name/Company: _____

Phone: _____ Fax: _____ Email: _____

☐ **RBT**

Therapist Name/Company: _____

Phone: _____ Fax: _____ Email: _____

☐ **PHYSICIAN**

Name: _____

Phone: _____ Fax: _____ Email: _____

☐ **PSYCHOLOGIST / PSYCHIATRIST**

Name/Company: _____

Phone: _____ Fax: _____ Email: _____

☐ **TUTOR**

Name/Company: _____

Phone: _____ Fax: _____ Email: _____

PLEASE RETURN THE COMPLETED FORM TO THE KESHER OFFICE.

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