



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 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.

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I give permission to Keshet 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.

KESHER L.D., INC.