ADMINISTRATION
Dr. John Hakonson, Superintendent
Mrs. Julie Myers, Curriculum Director
Mrs. Angela Kovarik, Student Services Director
Mr. Andrew Welch, Finance Director
Mrs. Kristi Jergensen, Technology Director
Mr. Bo Berry, Buildings, Grounds & Transportation Supervisor

300 S Washington Street   P.O. Box 890   Lexington, NE 68850   P: (308)324-4681   F: (308)324-2528

Date:_____

Re:_____**[Student Name]**

Dear_____
          PARENTS:

Lexington Public Schools is undertaking a review of all its student health plans due to recent changes in federal disability law. We may not consider your student's eligibility for these disability services without your permission.

Enclosed you will find a form which permits you to elect one of two options. First, you may decline additional evaluation if you are satisfied with your current health plan services and therefore opt out of any additional services and procedures which may be available under Section 504 of the Rehabilitation Act. Second, you may elect to permit the district to perform additional testing and evaluate whether additional services or the administration of those services is subject to change.

Regardless of how you choose to complete the form, your student will continue to receive the supports provided by his/her current health plan. Likewise, if you permit the school to conduct the evaluation analysis it does not necessarily mean that your student will receive different or additional services.

Please review the form and return it to _____, as soon as possible. I have enclosed a copy of a document that outlines your rights as a parent of a student who may have a disability. If you have any questions, please feel free to contact me.

Yours very truly,

Lexington Public Schools

Consent to Evaluate
Under Section 504 of the Rehabilitation Act

School: Lexington Public Schools   Date:_____

Student Name: _____

Date of Birth:_____ Age: _____ Grade: _____

Parent/Guardian Name(s):   _____

_____

I DO ☐ DO NOT ☐ consent to the assessment of my child to determine whether he/she qualifies as a student with a disability under Section 504 of the Rehabilitation Act. I understand that my consent may be revoked at any time prior to the completion of this assessment.

Parent or Guardian Signature: _____

Date:_____

Please return this document to the school district

FOR SCHOOL DISTRICT USE ONLY:

Received by: _____

Date: _____