First Name:	Date of Birth:

Fairview Park City School District
21620 Mastick Rd., Fairview Park, OH 44126
p: 440.331.5500 f: 440.356.3545
www.fairviewparkschools.org

Dr. William W. Wagner, Superintendent

Last Name:	Graduation Year:
Student Number:	
Document Type:	

PERMISSION FOR ASSESSMENT

Student: ____

School: ____ Grade: ______________________

First Language: ______________________________ Native Country: ______________________________

Reason evaluation has been requested: ____

____

____

Person(s) making referral: ____

____

Assessment:

Your child's English proficiency level will be assessed by evaluating the four language processes: listening, speaking, reading and writing.

Parent Response:

Please check one and sign.

________ I give my permission to proceed with the assessment.

________ I do not want assessment done at this time.

____ ______________________

Parent/Guardian Signature Date

This form should be returned to the ESL Teacher