**File Number:\_\_\_\_\_\_\_\_\_\_\_**

**FOUR RIVERS SPECIAL EDUCATION DISTRICT**

936 West Michigan

Jacksonville, IL 62650-3113

Phone: (217) 245-7174 Fax: (217) 245-5533

**WAIVER OF TEN DAY NOTICE/CONSENT REQUIREMENTS**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Name of Child Date of Birth Name of Parent/Guardian**

I, the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that any waiver of notice/consent requirements is voluntary. I understand that I may withdraw this waiver any time prior to the event(s) checked below.

**CHECK ONE:**

I AGREE to waive the ten (10) day requirement for the completion of the following:

Domain Meeting scheduled on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IEP Meeting scheduled on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eligibility Determination Conference scheduled on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I DO NOT AGREE to waive the requirements of a ten (10) day interval prior to the meeting(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Parent/Guardian

4R-72

Rev. 6/19