FREE TUTORING!
(SUPPLEMENTAL EDUCATIONAL SERVICES)
PROVIDER SELECTION FORM

Student's Name (printed): _____
School: _____ Grade: _____

Please read the information below and respond by checking the box that applies:

☐ I would like my child/legal ward to participate in free tutoring.

- o I am selecting the state-approved provider from the list provided to me.

  First Choice _____
  (Name of State-approved provider)

  Second Choice _____
  (Name of State-approved provider

  Third Choice _____
  (Name of State-approved provider

- o I understand that the district will enter into an agreement with the provider, and will either meet with the provider and me to set academic goals for my child, or closely examine the goals set by the provider and me.
- o I understand that if funds are insufficient to cover the tutoring services for all of the students who choose to participate, then participation will be based on prioritized academic need as defined by the district.
- o I understand that I have the right to terminate services early if progress made is unsatisfactory or the provider does not fulfill requirements as outlined in the agreement.
- o I understand that my child's name, phone number, and academic information will be given to the selected provider.
- o I understand that the provider will regularly inform my child's teacher(s) as well as myself of my child's progress.

☐ I would not like my child/legal ward to participate this academic year in the Supplemental Educational Services free tutoring program.

_____ _____
(Signature of parent/guardian) (Date)

_____ _____
(Printed name of parent/guardian) (Daytime telephone number)

_____ _____
(Address) (Evening telephone number)

RELEASE OF INFORMATION

STUDENT:_____ DATE OF BIRTH:_____

CURRENT GRADE:_____ STUDENT ID #:_____

PARENT'S NAME:_____ TELEPHONE:_____

ADDRESS:_____

_____ PERMISSION IS GRANTED FOR:

_____ PERMISSION IS NOT GRANTED FOR:

_____

(SCHOOL, AGENCY, CLINIC, OR PROFESSIONAL)

_____

(ADDRESS)

_____

(CITY) (STATE) (ZIP)

TO RELEASE/EXCHANGE INFORMATION REGARDING THE ABOVE NAMED STUDENT WITH:

Greenstreet Elementary

(SCHOOL, AGENCY, CLINIC, OR PROFESSIONAL)

329 S. 5th Street

(ADDRESS)

New Castle, IN 47362

(CITY) (STATE) (ZIP)

PURPOSE OF DISCLOSURE: _____

_____

NAME AND ADDRESS OF PERSON INITIATING THIS REQUEST: _____

_____

THE SPECIFIC INFORMATION TO BE RELEASED OR EXCHANGED: _____

_____

I HAVE BEEN INFORMED THAT I HAVE ACCESS TO AND MY REVIEW ANY OR ALL OF MY CHILD'S SCHOOL RECORDS AND IF SO DESIRE, TO CHALLENGE THE CONTENT OF THE RECORDS PROVIDED BY THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA) OF 1974.

SIGNED:_____ DATE:_____