

SIS Number: _____
(For Office Use Only)

ROCK FALLS TOWNSHIP HIGH SCHOOL DISTRICT 301

SUPPLEMENTAL EDUCATIONAL SERVICES PROVIDER SELECTION FORM

Student Information

Student Name _____
First Last

Date of Birth _____ Grade: 9 10 11 12
Month Day Year (Circle grade)

Check the box (or boxes) below if they apply to the student named above.

- English Language Learner (ELL) Language _____
 IDEA (Special Education)

Parent/Guardian Contact Information

Parent/Guardian Name _____
First Last

Mailing Address _____
Street City State ZIP Code

Telephone Number _____ E-mail _____

Selection of Supplemental Educational Service Providers

A list of Supplemental Educational Service (SES) Providers is enclosed. A code number has been assigned to each Provider. Please select your top three SES Providers by placing their assigned code number on the appropriate lines below (see enclosed sheet).

1st Choice - Code Number _____

2nd Choice - Code Number _____

3rd Choice - Code Number _____

Parental/Guardian Consent and Signature

As parent/guardian of the above-named student, I give my consent to Rock Falls Township High School District 301 to release student information to the supplemental educational service providers that I have selected.

Parent/Guardian Signature

Date