

SUMTER COUNTY SCHOOLS

Special Programs Department

WAIVER OF TEN CALENDAR DAY NOTICE / CONSENT REQUIREMENT

Name _____

DOB _____

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

CHECK ONE:

I AGREE ____

I DO NOT AGREE ____

to waive the requirements of a ten (10) calendar day interval prior to :

Parent Guardian Consent for Evaluation _____

Notification of IEP Meeting / Amendment/ Conference _____

Date: _____

Signature of Parent/Guardian: _____