

Supplemental Educational Services Provider Selection Form

Student Name: _____

Home Address: _____

Home Phone #: _____

Cell Phone #: _____

Parent(s)/Guardian(s): _____

School: _____

Grade: _____

Check the box that applies:

My son/daughter **WILL** participate in the Supplemental Educational Services program.

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

(Supplemental Educational Services Provider)

I understand that the district will enter into an agreement with the provider, and I will be notified of a time to meet with the provider to set goals for my child.

I understand that the provider will regularly inform me and the student's teacher(s) of my child's progress.

I understand that if funds are insufficient to cover the supplemental educational services for all of the students who choose to participate, participation will be based on prioritized academic need as defined by the district.

Signature of parent/guardian **Date**

(Printed name of parent/guardian) **Date**