Title 1/New Franklin Supplemental Educational Services
2009-2010

____
Student's Full Name (Printed)

Please read and check the boxes below, by checking the boxes you have read and agreed to the following statements:

My son/daughter **WILL** participate in the Supplemental Educational Services program as it is described in *No Child Left Behind*.

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

I select ______________________________________.
(State-approved provider's name)

Second choice ______________________________________.
(State-approved provider's name)

☐ 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 student.

☐ I understand that the provider will regularly inform me and the student's teacher(s) of the student'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)

____
(Home telephone number)

____
(Cell phone number)