Texas Conference of Seventh-day Adventists
Office of Education
PO Box 800 | Alvarado, TX 76009

DIAGNOSTIC TESTING AGREEMENT FORM
REACH

Diagnostic Testing Agreement For _____
Students Name

I understand that I am agreeing to taking the student listed above to receive testing from The Diagnostic Learning Services at the request of _____ from _____
Teacher School

Please initial:

___I understand that this is diagnostic testing and that there may be other service necessary for this student to reach their highest potential of learning that will be my financial responsibility. The Texas Conference of Seventh-day Adventists is willing to pay for the testing done at The Diagnostic Learning Services, provided there are funds available, and all of the REACH documents have been summited to the Office of Education.

___I understand that cancelations or rescheduling of the diagnostic testing must be done 48 hours before appointment.

___I understand that if I do not cancel or reschedule 48 hours before my appointment I will incur a cancelation fee of $350.00 assessed directly to me.

Signature:_____ Date:_____
Parent or Guardian

Signature:_____ Email:_____
Teacher

School Name:_____ Phone:_____

Address:_____

_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize The Diagnostic Learning Center to release any information/testing results to the teacher and school listed above.

Signature:_____ Date:_____
Parent or Guardian

Witness:_____ Title:_____ Date:_____

Please print the following information:

Student's Name:_____ Date of Birth:_____

Parent or Guardian Name:_____

Phone Number:_____ Email:_____