
**PARENT/GUARDIAN REFUSAL
FOR STUDENT PARTICIPATION IN DISTRICT MAP TESTING**

Date: _____ (This form is only applicable for the current school year)

Student First Name: _____

Student Last Name: _____

Student Date of Birth: _____

Student School: _____

Reason for refusal (REQUIRED):

Parent Guardian Name (print) _____

Parent Guardian Signature _____

Return this form (by mail, fax, or email) to the Department of Research, Evaluation and Assessment **three weeks before the start date** of MAP testing in the student's school. Test dates are posted to the district website under the Department of Research, Evaluation and Assessment.

Department of Research, Evaluation and Assessment

1350 West 106th Street

Bloomington, MN 55430

Phone: 952-681-6486

Fax: 953-681-6563

Email: ekarges@isd271.org