

The following form(s) can be filled in on-line, then printed for signatures and mailing or faxing.

To begin filling out the forms in Acrobat Reader, make sure the '**hand**' tool is selected then click on a line or in a box and begin typing. Check boxes can be clicked on or off.



# Spokane County Head Start/ECEAP/EHS **CONSENT FOR SCREENING, ASSESSMENT AND EXCHANGE OF INFORMATION**

Child's name \_\_\_\_\_ Birth date \_\_\_\_\_

Parent/guardian name \_\_\_\_\_ Phone number \_\_\_\_\_

Parent/guardian address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Medical/Medicaid number \_\_\_\_\_

Doctor's name \_\_\_\_\_ Phone number \_\_\_\_\_

Doctor's address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Site \_\_\_\_\_ Classroom \_\_\_\_\_ Session:  AM  PM  
 Full day

**SERVICES ARE REQUESTED AS FOLLOWS:**

YES NO

- Special education assessment
- Motor assessment
- Speech/language assessment
- Hearing assessment
- Referral to Child Find (Infant Toddler Network (ITN) or School District) for assessment of:

\_\_\_\_\_

Results of referral:  Qualify  Not qualify Date \_\_\_\_\_

- Audio/video tape
- If qualified, ongoing speech/language services, occupational therapist, physical therapist, special education \_\_\_\_\_
- Exchange of information, including evaluations and well-child exams, with local school districts, University Programs in Communications Disorders, Infant Toddler Network, Department of Developmental Disabilities and other service providers (list):**

\_\_\_\_\_

**THE ABOVE ASSESSMENT AND SERVICES WILL BE PROVIDED BY: (check one)**

- Head Start consultants
- University Programs in Communications Disorders (UPCD) graduate students, under the direct supervision of a certified speech language pathologist
- Other (specify) \_\_\_\_\_

As parent/guardian, I give permission for my child to receive the above designated services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff signature \_\_\_\_\_ Date \_\_\_\_\_

Staff address \_\_\_\_\_ Staff phone \_\_\_\_\_

Date sent to provider \_\_\_\_\_

**Attachments to include when referring to ITN: Denver II; Child Individual Plan; Well-Child Exams; Child Developmental History; Health, Dental and Diet History; and other assessments as appropriate.**

**VALID FOR ONE YEAR FROM DATE OF SIGNING  
 PARENT/GUARDIAN MAY REVOKE THIS AUTHORIZATION IN WRITING AT THEIR DISCRETION**