Community Colleges of Spokane

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

Reset Form

PLEASE PRINT INFORMATION

Child's last name _____ First _____ M.I. _____ Birth date _____

Site _____ Classroom _____ Session: ☐ AM ☐ PM ☐ Full day

Parent/Guardian name _____ Phone number _____

Parent/Guardian address _____ City _____ Zip _____

SERVICES ARE REQUESTED AS FOLLOWS:

Referral to Child Find (Check one)

☐ **Infant Toddler Network (ITN)**
Send attachments: Sensory screenings, ASQ-3.
(At further request: *Child Developmental History*, *Health*, *Dental & Diet History*, other EHS assessments as necessary.)

☐ **(PS) School District** _____
Send attachments: Sensory screenings, ASQ-3.
(At further request: *Child Developmental History, Health, Dental & Diet History,* other HS assessments as necessary.)

Evaluation Requested (Check area(s) of concern)

☐ Speech/language
☐ Hearing
☐ Social/Emotional
☐ Self Help
☐ Large Motor (PT)
☐ Small Motor (OT)
☐ Cognitive/Pre-academic

A CHILD qualifying for an EVALUATION AND ASSESSMENT WILL BE...

☐ (PS) School District/Home School _____
(Name)
☐ Infant Toddler Network
☐ Other (specify): _____

Exchange of Information (Check all that apply)

☐ (PS) School District _____
(Name)
☐ Infant Toddler Network (ITN)
☐ Other service providers: _____
(Name)

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

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

Staff Address _____

Staff phone _____ Staff fax _____ Date sent to provider _____

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

Original – Provider

Copy – Parent