**Consent Form**

**Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_Evaluator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to the following:

 *(Parent’s name-please print)*

**Please initial each line to which you give MKSA LLC./HASC consent.**

\_\_\_\_ **Core Evaluation** Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Family Assessment (Department of Health Form) **offered and declined** (EI only)

 \_\_\_\_ Family Assessment (Department of Health Form) **offered and accepted** (EI only)

 \_\_\_\_ Release all information from the evaluation(s) to the Department of Health/School District.

 \_\_\_\_ Review of any other current examinations, evaluations, or assessments performed for the purpose of (diagnosis/additional information) *specify:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Obtain and child’s current health status form from parent and/or health care provider necessary to complete the evaluation and to provide ongoing services.

\_\_\_\_ **Supplemental Evaluation** Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Release all information from the evaluation(s) to the Department of Health/School District.

 \_\_\_\_ Review of any other current examinations, evaluations, or assessments performed for the purpose of (diagnosis/additional information) *specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**For All Evaluations:**

\_\_\_\_ I consent to have the evaluation(s) (summary or report(s)) sent to my child’s health provider.

\_\_\_\_ I consent to have the outcome of the evaluation(s) discussed with the doctor named below.

\_\_\_\_ I consent for MKSA LLC./HASC, to obtain any prescriptions necessary for evaluations or

 if found eligible, treatment from the doctor named below.

 *Please indicate your child’s health care provider:*

**Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

This consent may be revoked at any time.

**Parent E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For informational purposes only

***COMPLETE THE FOLLOWING FOR EI ONLY:***

***Are there transportation needs related to the following: (if yes, give specific details below)***

Ability to provide transportation \_\_\_Yes \_\_\_No Special needs of child related to transportation \_\_\_Yes \_\_\_No

Safety issues/parental concerns related to transportation \_\_\_Yes \_\_\_No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11/14 pm - V:\Evaluation forms\evaluation consent 11.13.doc