



2.2.3 District Inclusive Education Services Parental Consent For Consultation Form

Student Name:		Grade:
School:	Teacher:	
Inclusion Support Teacher:	Parent/Guardian:	
Email Address:		
Parent/Guardian (1) Cellphone:	Parent/Guardian (2) Cellphone:	School Year:

Parent Consent for Service: Check the ones parent provides consent for consultation:

- ☐ District School Psychologist
 ☐ District Inclusion Support Teacher Coordinator
☐ Speech & Language Pathologist
 ☐ District Program Screening (eg: Kindergarten SLP, Hearing, Vision)
☐ Mental Health and Addictions Coordinator
 ☐ District Based Team (Consult)
☐ Teacher of the Deaf & Hard of Hearing
 ☐ Vision SLP
 ☐ Occupational Therapist
☐ Vision Teacher
 ☐ Assistive Technology (ASD, SET BC)
 ☐ Physiotherapist

Authorization is granted on this date _____ District Services as noted above:

(Legal Guardian)

(Legal Guardian)

(School Inclusion Support Teacher)

(Principal)

Names & contact number of professionals who have worked with/are working with students:

(Optional- parent completes)

- | | |
|---|---|
| ☐ Indigenous Services: _____ | ☐ Youth Probation/Forensics: _____ |
| ☐ Child & Youth Mental Health: _____ | ☐ Ped/Phys: _____ |
| ☐ Private Counselling: _____ | ☐ Psychiatrist: _____ |
| ☐ Ministry of Children & Families: _____ | ☐ Speech & Language: _____ |
| ☐ OT/PT: _____ | ☐ Audiology: _____ |
| ☐ Community Support Programs: _____ | ☐ Other: _____ |

For District Office only

Reviewed By: _____

(Signature)

(District Staff)

(Date)

Entered in Laserfiche _____

Emailed to Staff _____