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 ☐ Occupational Therapist

☐ Vision Teacher ☐ Assistive Technology (ASD, SET BC) ☐ Physiotherapist

Authorization is granted on this date_____ District Services as noted above:

_____ _____ _____ _____

Legal Guardian 1 Signature Print Legal Guardian 2 Signature Print

_____ _____

(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 _____