CONSENT FOR HEALTH CONSULTATION SERVICES FOR THE CHILD

I, _____, give permission for my child, _____
full name of parent/guardian *full name of child*

to receive the services **checked and initialed** below. The purpose of these services is to understand and address my child's needs within the context of their child care program. These services will be provided or administered by

_____.
full name of Child Care Health Consultant

- ❑ Observation of my child in his/her child care setting.
- ❑ Consultation with program staff regarding my child's health, safety and/or behavior.
- ❑ Consultation with family regarding my child's health, safety and/or behavior.
- ❑ Developmental and/or health screening (including, but not limited to, speech, vision and hearing)
- ❑ Health and/or Child Care Records review (please specify): _____
- ❑ Health assessment
- ❑ Developmental assessment
- ❑ Behavioral assessment
- ❑ Other (please specify): _____

I understand that information regarding my child is generally confidential and may *not* be given to employees of other schools, public agencies or individual professionals in private practice without my consent or other legal requirement. My signature on this form provides permission for results of the above-checked service(s) to be shared with staff at _____. Further, _____
full name of child care program *name of Child Care Health Consultant*

is authorized to share the information gained with his/her supervisor(s) and/or child care health consulting staff working directly with her/him. Consent for release of information and authorization of communication shall be for the purpose of understanding and addressing my child's needs.

This consent is voluntary and I understand that I can withdraw my consent for my child at any time. Unless I withdraw this consent, this authorization will be effective for the period my child is continuously enrolled in the _____. By signing below I am confirming that I have read, understood and
name of child care program

agree to the above conditions and services.

Parent/Guardian Name: _____
print full name

Parent/Guardian Signature: _____ **Date:** _____

NOTE: In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable California laws, all personal and health information is private and must be protected.