NASSAU COUNTY DEPARTMENT OF HEALTH OFFICE OF CHILDREN WITH SPECIAL NEEDS Early Intervention Program Physically Handicapped Children's Program

<u>CONSENT FOR PARTICIPATION IN THE EARLY INTERVENTION PROGRAM/</u> <u>CHILD FIND PROGRAM AND RELEASE OF INFORMATION</u>

Child's Name

First

DOB ____/___/

Please check off each box where you give consent:

Last

- □ Have a Child Find/Early Intervention Program Professional administer a developmental screening test to my child periodically.
- □ Refer my child to the Early Intervention Program for a more in-depth evaluation if a developmental delay is identified or suspected as a result of a screening test.
- □ Notify my child's health care provider of participation in Early Intervention Child Find.
- □ Provide my child's health care provider with developmental screening and/or evaluation and IFSP results upon their request.
- □ Share/Obtain pertinent medical information and/or developmental information from my child's health care provider.
- □ Send referral information to the initial multidisciplinary evaluation team.
- □ I have reviewed a copy of "A Parent's Guide," a reference manual for the New York State Early Intervention Program from the New York State Department of Health which is available on the state web site at www.health.ny.gov/publications/0532/ (*Include slash at end of email address*).

 \Box Other (specify & obtain):

- Transfer record to another county. Specify______
- I understand my rights and responsibilities in obtaining Early Intervention services from the Nassau County Department of Health. I agree to actively participate in the program in accordance with these rights and responsibilities. I consent to the evaluation of my child and to the coordination and planning of services by the Early Intervention Service Coordinator. I have been provided the necessary information to choose an evaluator.
- I understand that I may withdraw my consent to release information/or cease to participate in this program at any time.
- I understand my child's record will be destroyed on/about child's 21st birthday.
- I understand that the Evaluation/Progress Report/IFSP and Review Plan will be shared with my child's Early Intervention IFSP team members.
- Name of Evaluation Agency:

Parent/Guardian Signature

/

Date