Consent to Release Information

Child's Name	
Date of Birth (Day-Month-Year)	
Parent/ Guardian Name(s)	
Home Mailing Address (Include Postal Code) **The EYEDA results will be sent to this address**	
Telephone number to contact you for an appointment for the EYE-DA	**Home:** **Mobile:** **Other:**
Email (Please print in UPPERCASE letters)	
Language(s) spoken at home	
Does your child speak and understand English?	
Are there any additional services your child receives?	○ **Children's Rehab Team (Woodbridge, URV Hospital)** ○ **VIVA (Autism Services)** ○ **Speech Language or Talk with Me** ○ **Other _____**
Does your child attend preschool/daycare?	
School child will be attending	

I, _____, (Parent/Guardian) of _____, (child's name) give Family and Early Childhood West Inc. permission to:

- ☐ Assess my child using the Early Years Evaluation: Direct Assessment, the EYE-DA and send the results to the address provided.
- ☐ Share the EYE-DA assessment information and progress reports on any interventions that may have been offered to my child with their school personnel, Anglophone School District West personnel and the Early Childhood Services personnel

Parent's signature: Date:

_____ _____

_____ _____

Consent to Release Information

For Office Use Only

Child's Name: _____

School: _____

Date Received: _____

Record of Contact:

_____

_____

_____

_____

EYE-DA Appointment Date and Time

_____

_____

_____

_____

Notes: