Attachment I

Erie County Help Me Grow Early Intervention Collaborative
Kaleidoscope Center
4405 Galloway Road Sandusky, Ohio
419-621-3962 1-800-491-4566 FAX 1-419-625-3448

Consent for Help Me Grow Services

Child's Name: ______________________________ DOB: ____________

A. By my signature and initials below by each service, I give permission for my child/family to receive ongoing Help Me Grow (HMG) Services, including but not limited to,
_______ developmental screening/assessment,
________ multi-disciplinary evaluation, referral and therapy. I understand that if I do not provide consent for evaluation and assessment in all five areas, including vision, hearing, and nutrition, then my child will not receive any Part C Services.
_______My child has a medical condition and/or obvious and immediate needs that are identified at the time of referral. I give consent for an Individualized Family Services Plan (IFSP) to be developed and services to begin immediately.
_______ Private Insurance is used to pay for any specialized services my child may receive.

I understand that I may accept/decline part of any ongoing HMG services without jeopardizing other services. My signature also indicates that I am fully aware of the intent and purpose of the HMG system and its services that are available.

Signature: ________________________________ Relationship to child: ____________
Witness: _________________________________ Date: ______________________

Authorization to Exchange Information

B. The following persons/agencies have my permission to exchange pertinent information about medical services, therapies, or educational services via verbal, written, electronic, video, and audio means:

____
____
____
____
____

All matters relating to this child are considered confidential and may be shared only with the agencies listed above. **This consent will continue in effect until it is revoked in writing by the parent or when the child no longer receives Help Me Grow Services.**

Signature:________________________________Relationship to child: ____________
Witness: ________________________________Date: ________________________