Southeastern Alberta Student Health Partnership

AUTHORIZATION FOR SERVICES

I, _____ (parent/guardian) authorize my child, _____ to be referred to the Student Health Initiative and

I consent to my child being assessed by Student Health Initiative health service providers, and receiving services as may be directed or recommended by Student Health Initiative personnel, as follows:
(please check all that apply)

- ☐ Behavioral/emotional (mental health)
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Respiratory therapy
- ☐ Speech/language/hearing
- ☐ Family school liaison
- ☐ Student health consultant (Grasslands)

Consent for photography/audio/videotaping

I, _____ (parent/guardian)

- ☐ do hereby consent
- ☐ do not consent

to Student Health Initiative personnel photographing and/or recording sessions via audio/visual means for evaluating treatment programs, consultation, training purposes, and/or to review therapy/progress. I understand that, if I consent to photographing/audio/videotaping my child, this information will not be used outside of the Student Health Initiative program unless express written consent is obtained.

Consent for student participation

I, _____ (parent/guardian)

- ☐ do hereby consent
- ☐ do not consent

to students interested in provision of health services to children in schools observing my child in therapy, and assisting the therapist as appropriate.

I understand that this consent if valid until _____ (not to exceed one year).

I understand that I may revoke this consent at any time by notifying the Student Health Initiative service provider in writing.

_____ _____
Signature of parent or guardian Date

_____ _____ _____
Signature of witness Title of witness Agency of witness