Region #9 Family School Liaison Worker

CONSENT FORM

Student Name: **Sex:** **DOB:**

Grade: **Student ID#** **Parkdale School**

The Personal Information Collected is under the authority of Region #9 Student Health Initiative Partnership and will be used to determine appropriate services to be provided. The privacy provisions of the Freedom of Information and Protection of Privacy Act protect the information gathered.

By signing below, I authorize the Family School Liaison Worker, **Mrs. L Lucas**, to work with my child, provide coordinated services and make referrals as needed.

Individual ☐ **Group** ☐ ____________________

PRESENTING ISSUES

EMOTIONAL OR BEHAVIORAL: ____

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SCHOOL BASED: ____

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HEALTH OR HOME: ____

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NAME OF PARENT/GUARDIAN __________________________________ *DATE:* ______________

SIGNATURE OF PARENT/GUARDIAN __________________________________

ADDRESS: ____

PHONE: ______________________ *(HOME)* ________________________*(WORK/CELL)*

- This consent is in effect until such time as I formally withdraw it or until services are concluded -