Newfoundland & Labrador

Child Care Inclusion
Consent to Obtain/Release Information

Section A – Information to be completed by person(s) providing consent			**New** **Renewal**
Name of child whom the information pertains:			**Date of Birth:** YYYY/MM/DD
Presenting Concerns:			**Preferred Spoken Language:**
Street Address:	**City/ Town:**	**Province:** NL	**Postal Code:**

Section B: Child Care Centre Information	
Name of Child Care Service	**Address/phone of Child Care Service**

Section C – Current Supports Identified and/or in Progress (check all that apply)

Type of Support	Referred	Active	Name of Professional and contact (email/phone number)
ISSP or IPP – support plan	☐	☐	
Pediatrician	☐	☐	
Direct Home Services Program	☐	☐	
Occupational Therapist	☐	☐	
Physiotherapist	☐	☐	
Speech Language Pathologist	☐	☐	
Child/Behavior Management Specialist	☐	☐	
Children, Seniors and Social Development	☐	☐	
Regional Autism Services	☐	☐	
Other _____	☐	☐	

Section C: Consent (to be completed by person(s) providing consent)

I / We, the Parent(s) Legal Guardian(s) of the above named child, give consent for an **ELICD Delegate** of the department of Education (EDU) to:

Obtain and/or release the following information to be shared for the purpose of supporting inclusive practices in the child care service where applicable:

- Recordings/Observations completed by Administrator/Staff of the child care service;
- Receive/release multi-disciplinary reports/assessments from employees of the Service and professionals listed above relevant to the child; and
- Consult with the professionals and identified Child Care Service involved with the family.

I am giving this consent of my own free will and I reserve the right to revoke my consent at any time by contacting a Department of Education delegate in writing and withdrawing my consent. The consent is only valid between the Department of Education and the person(s) named herein and is valid for one year from the date signed.

1.			
	Name of Person Providing Consent	**Signature**	**Date (YYYY/MM/DD)**
	Email Address:	**Phone Number:**	
2.			
	Name of Person Providing Consent	**Signature**	**Date (YYYY/MM/DD)**
	Email Address	**Phone Number:**	

EDU OFFICE USE ONLY

Name of EDU Delegate	**Signature**		**Date (YYYY/MM/DD)**
Street Address	**City/Town**	**Postal Code**	**Telephone**

PRIVACY NOTICE

The information collected on this form is collected under the authority of the *Child Care Act* and the *Access to Information and Protection of Privacy Act (ATIPPA)* and is used solely for the purposes of administration/operation of the child care inclusion program provided by the Early Learning, Inclusion and Child Development Division. This information is kept confidential and held securely as required by *ATIPPA*. If you have any questions about the collection or use of this information, please contact the Information Management Division of the Department of Education at 709-729-6281.