

# Children's Therapy and Family Resource Centre

801 McGill Road, Kamloops, BC V2C 6R1 Phone: (250) 371-4100 Fax: (250) 371-4120  
www.kamloopschildrenstherapy.org

## School Aged Consent Form

Child's Name:

Date of Birth:

I, \_\_\_\_\_ (legal guardian's name), do hereby authorize the staff of the Children's Therapy and Family Resource Centre to provide my child with clinical services.

I hereby authorize the Children's Therapy and Family Resource Centre to obtain and release information relevant about my child, to and from the following agencies/persons.

### (Please initial each applicable box)

- |  |  |
|--|--|
| <input type="checkbox"/> At Home Program   | <input type="checkbox"/> Pediatrician:   |
| <input type="checkbox"/> Autism Diagnostic Team<br>(Coordinator, Interior Children's Assessment Network,<br>Psychologist, SLP, OT, Pediatrician) | <input type="checkbox"/> Preschool/Daycare:  |
| <input type="checkbox"/> BC Children's Hospital  | <input type="checkbox"/> Public Health (IHA)<br>(Public Health Nurse, Dietician, Speech Therapist,<br>Audiologist) |
| <input type="checkbox"/> Community Living BC (CLBC)  | <input type="checkbox"/> School District:  |
| <input type="checkbox"/> Child and Youth Mental Health   | <input type="checkbox"/> # 73 (Kamloops Thompson)  |
| <input type="checkbox"/> Equipment Dealer:   | <input type="checkbox"/> #58 (Merritt)   |
| <input type="checkbox"/> Family Physician:   | <input type="checkbox"/> #74 (Gold Trail)  |
| <input type="checkbox"/> Foster Family:  | <input type="checkbox"/> Other:  |
| <input type="checkbox"/> Infant Development Program  | <input type="checkbox"/> Sunny Hill Health Centre for Children   |
| <input type="checkbox"/> Interior Community Services   | <input type="checkbox"/> Other Family Members:   |
| <input type="checkbox"/> Ministry for Children and Family Development  | <input type="checkbox"/> Other Agency/Person:  |
| <input type="checkbox"/> Orthotics/Prosthetics Services:   |  |

I hereby authorize the staff of CTFRC to help my child with toileting needs as required.

I hereby give my consent to allow audio/visual records to be taken of my child for the following reasons:

- To be used for the child's treatment. This information may be shared with the child's team.
- To be used for teaching and workshops. It is understood that the child will not be identified by name. I waive all rights to payment or royalties in connection with any presentation of these photographs/videos now and in the future.
- To be used by the Children's Therapy and Family Resource Centre now and in the future for public community relations, eg. brochures, display boards, print material and fund raising.

Signature:

(Legal Guardian *electronic signature assumed*)

Date:

Relationship to Child:

**This consent is valid until your child graduates from school or until he/she is discharged from services at the centre. Please contact the centre if you wish to make any changes to this consent at any time.**