Children's Therapy and Family Resource Centre

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www.kamloopschildrenstherapy.org

School Therapy Program 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)

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

☐ 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: _____ Date: _____
(Legal Guardian)

Relationship to Child: _____

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