

Please ensure all information is completed and easy to read.

CONSENT TO OBTAIN INFORMATION

Name of Child _____ (**Print Name**) **Child's Birthdate** (Month/Day/Year) _____

I, the undersigned, do hereby authorize The Centre for Child Development to **OBTAIN** medical/educational information regarding my child from the following persons/agencies listed below.

[PLEASE INITIAL INSIDE EACH BOX YOU CHOOSE]:

<table border="0" style="width: 100%;"> <tr><td style="width: 20px; text-align: center;"><input type="checkbox"/></td><td>Infant Development Program _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Supported Child Development Program _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Preschool/daycare/school _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>School District _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Child's Doctor(s) (*Please list first and last names) _____</td></tr> <tr><td colspan="2">_____</td></tr> <tr><td colspan="2">_____</td></tr> <tr><td colspan="2">_____</td></tr> </table>	<input type="checkbox"/>	Infant Development Program _____	<input type="checkbox"/>	Supported Child Development Program _____	<input type="checkbox"/>	Preschool/daycare/school _____	<input type="checkbox"/>	School District _____	<input type="checkbox"/>	Child's Doctor(s) (*Please list first and last names) _____	_____		_____		_____		<table border="0" style="width: 100%;"> <tr><td style="width: 20px; text-align: center;"><input type="checkbox"/></td><td>Surrey Memorial Hospital _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>BC Children's Hospital _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Sunny Hill Health Centre _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Orthotist _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Foster Parent(s) _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>M.C.F.D. Social Worker _____</td></tr> <tr><td style="text-align: center;"><input type="checkbox"/></td><td>Other Professionals involved with Child (please list) _____</td></tr> <tr><td colspan="2">_____</td></tr> <tr><td colspan="2">_____</td></tr> </table>	<input type="checkbox"/>	Surrey Memorial Hospital _____	<input type="checkbox"/>	BC Children's Hospital _____	<input type="checkbox"/>	Sunny Hill Health Centre _____	<input type="checkbox"/>	Orthotist _____	<input type="checkbox"/>	Foster Parent(s) _____	<input type="checkbox"/>	M.C.F.D. Social Worker _____	<input type="checkbox"/>	Other Professionals involved with Child (please list) _____	_____		_____	
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CONSENT TO RELEASE INFORMATION

I also authorize The Centre for Child Development to **RELEASE** reports and verbally share medical/ educational information regarding my child with the persons/agencies listed below.

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CENTRE REPORTS WILL BE SENT TO PARENT(S) AND/OR GUARDIAN IN ACCORDANCE WITH CENTRE POLICY

Name of Parent/Guardian authorized to give consent	Signature	Date (Consent expires one (1) year from this date)
Name of Child (age 14 yrs or over) if appropriate (Print Name)	Signature	Date

Please Note: The Centre reserves the right to require proof of guardianship or proof of change of guardianship at its discretion.