

Health Screening is a process used to identify children who may need further assessment and/or interventions. The attached information sheet describes the Health Screening that will be offered within your child's program. Health Screening will not occur without your consent. You must sign this form for your child to have the screening.

Demographics		
Child's Legal Name (Last, First)		Date of Birth (yyyy-mon-dd)
Personal Health Number		<input type="checkbox"/> Male <input type="checkbox"/> Female
Program/Site/School	Teacher/Class	Grade

Type of Screening	
I give consent for my child to having the health screening I have put my initials beside. My child will only receive the services that I have initialed. If you do not wish any screening services, write <i>refused</i> across this area and return to the school.	Initials
Occupational Therapy	
Speech Language Pathology	
Physiotherapy	

Declaration of Consent	
By signing this consent, I am giving consent for my child to have Health Screening done. I confirm that: <ul style="list-style-type: none"> - I have read the attached information sheet regarding the nature, risks, and benefits associated with the health screening. - I am aware that I must contact the Alberta Health Services (AHS) staff listed on the information sheet if I have any questions about health screening or if I have any concerns about my child receiving the health screening service. - I am satisfied with and understand the information I have been given in the information sheet and to any questions or concerns I have discussed with AHS staff listed on the information sheet. - I understand that I may, at any time, withdraw this consent to the service(s) initiated above by calling the AHS staff listed on the information sheet. - I confirm that I have legal authority to provide consent. 	
Name of Person(s) Giving Consent (<i>print</i>)	Relationship to Child <input type="checkbox"/> Parent (<i>with authority to provide consent</i>) <input type="checkbox"/> Guardian <input type="checkbox"/> Other (<i>specify</i>) _____
Daytime Phone Number	Alternate Phone Number
Signature or Person(s) Giving Consent	Date (yyyy-Mon-dd)

Alberta Health Services collects health information in accordance with Section 20 of the *Health Information Act* (HIA) for the purpose of providing health services, determining eligibility for health services, or to carry out any other purpose authorized by the HIA. If you have any questions about this collection, please ask your health care provider or contact the Chief Privacy Officer at 1-877-476-9874

For Office Use Only <i>(if applicable)</i>			
Telephone/Fax Consent			
Mode Received	Name of Person Obtaining Consent <i>(print)</i>	Signature	
<input type="checkbox"/> Fax/Scan	Date <i>(yyyy-Mon-dd)</i>	Time	
<input type="checkbox"/> Telephone			
Consent Using an Interpreter <i>(for non-English speaking parent/client)</i>			
Name of Interpreter	Telephone	Date <i>(yyyy-Mon-dd)</i>	Time