**Westside Regional Center**

**Parents' Consent for Assessment**

Child_____Birth Date_____UCI #_____

Primary Language at Home_____Agency_____Date_____

Consent for Assessment

Dear Parent or Guardian;
An individual evaluation to determine whether your child needs to begin or continue receiving early intervention services from agencies participating in the Early Start Program is needed. The assessment will help to identify your child's strengths and areas of need. The assessment may include: 1) observation of your child at home or other appropriate settings; 2) an interview with you; 3) review of medical or other reports you agreed to share; and 4) evaluation using a Bayley IV and/or DAYC-2.

The assessment may be conducted in any or all of the following areas:
☐ Cognitive development
☐ Physical development, including a recent vision, hearing, and health status
☐ Communication development (expressive and receptive language)
☐ Social/Emotional development
☐ Adaptive development
☐ Family Needs Assessment: *The Individual Family Service Plan (IFSP) is required, with the concurrence of the family, to include a statement of the family's concerns, priorities and resources related to enhancing the development of the child.*

Assessment May be Completed by:

| | | |
|---|---|---|
| ☐ Psychologist | ☐ Teacher | ☐ Physical Therapist |
| ☐ Speech and Language Specialist | ☐ Hearing Impaired Specialist | ☐ Occupational Therapist |
| ☐ Teacher for the Visually Impaired | ☐ Nurse | ☐ Orientation/Mobility Instructor |
| ☐ Community Mental Health | ☐ Physician | ☐ Early Intervention Specialist |

☐ Other (specify)_____

☐ *I consent to an evaluation/assessment of my child for purposes of determining eligibility and/or determining early intervention needs.*

☐ *I consent to a Family Needs Assessment. This information will be included in the IFSP to help identify family priorities, needs, and resources related to my child.*

*I understand that the results will be kept confidential and that I will be invited to attend the IFSP meeting to discuss the assessment results. It is also my understanding that no services will result without my written permission.*

Signature of Parent/Guardian: _____ Date: _____

IFSP Team Member _____ Position _____

Agency _____ Phone number _____

Address_____City _____State_____

*Should you have questions regarding this assessment, do not hesitate to call the above named person.*