

**PARENT INFORMATION RELEASE FORM**

Dear Parent:

Through the district's review of existing evaluation data, a therapy evaluation to be administered jointly by a physical therapist and an occupational therapist, was recommended for your child. A medical referral will need to be completed by a physician prior to evaluation. Evaluation recommendations will address therapy services based on your child's educational, rather than medical, needs. Periodic update of the parent information release form may be requested.

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Phone: (H) ( ) (W) ( )

Parent to be contacted during the day: \_\_\_\_\_ Phone: ( )

School District: \_\_\_\_\_ Campus: \_\_\_\_\_

1. It is often important for the therapist to be able to contact your child's physician to assist in promoting an integrated approach to service delivery within the school setting. Please list all physicians your child sees on a regular basis with the phone number.

NAME	PHONE
_____	( ) _____
_____	( ) _____
_____	( ) _____

2. Does your child receive services from Scottish Rite Hospital? \_\_\_Yes \_\_\_No TSRH# \_\_\_\_\_

3. List other hospitals, clinics, or rehabilitation centers where your child receives services:
- \_\_\_\_\_ ( ) \_\_\_\_\_
- \_\_\_\_\_ ( ) \_\_\_\_\_

4. Various substances, foods, liquids may be used during evaluation or therapy. Does your child have any known allergies to substances, foods, or liquids? \_\_\_Yes \_\_\_No If YES, please list the allergens, being as specific as possible: \_\_\_\_\_
- \_\_\_\_\_

5. Does your child have any difficulty with choking, swallowing, and/or chewing regular table foods? \_\_\_Yes \_\_\_No If YES, please describe: \_\_\_\_\_
- \_\_\_\_\_

6. List concerns that you and your family have for your child in the home/school settings:
- \_\_\_\_\_
- \_\_\_\_\_

7. List goals/desired educational outcomes that you and your family have for your child in the home/school settings: \_\_\_\_\_
- \_\_\_\_\_

8. Do you give your permission for the occupational/physical therapist to contact your child's physician(s) and other past and/or present service providers to obtain and share information? \_\_\_Yes \_\_\_No

This parental release form will remain in effect until withdrawn or updated. Consent may be withdrawn at any time.

\_\_\_\_\_  
Parent/Guardian's signature

\_\_\_\_\_  
Date

**THIS INFORMATION IS TO BE USED WITH PROFESSIONAL STAFF ONLY IN KEEPING WITH FERPA AND IDEA CONFIDENTIALITY REQUIREMENTS 06/06**

It is the policy of Region 10 Education Service Center not to discriminate on the basis of race, color, national origin, gender or handicap in its vocational programs, services or activities as required by Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; and Section 503 and 504 of the Rehabilitation Act of 1973, as amended. Region 10 Education Service Center will take steps to ensure that lack of English language skills will not be a barrier to admission and participation in all educational programs and services.