Parent/Guardian Consent Form

PARENT/GUARDIAN NAME_____

CHILD_____ **DOB**_____
CHILD_____ **DOB**_____
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CHILD_____ **DOB**_____

I give consent for the Early Intervention Specialists with the Early Learning Coalition to complete the following: Developmental screenings (ASQs) and/or developmental/behavioral observations. The results of this screening and/or observation will be shared with the parent. I am aware that I may withdraw this consent in writing at any time.

Please check one:
I authorize consent. ☐ **I decline consent.** ☐

I give consent to the Coalition or contracted staff to engage in verbal, written, or electronic communication about the developmental and/or behavioral status of my child with the following service providers/community programs. Consent may not be denied for review of information to federal or state funding payment.

Children's Medical Services
Department of Children & Families
Early Steps
Escambia County School District
Early Learning Coalition of Escambia County
Families First Network
Fl Diagnostic & Learning Resources System (FLDRS)
Division of Early Learning

Please check one:
I authorize consent. ☐ **I decline consent.** ☐

I am aware that I may withdraw this consent in writing at any time.

_____ **Date**_____
Signature of Parent/Guardian

Authorization is valid for the period the participant remains in the program or withdraws their consent.

A PHOTOSTAT OF THIS SIGNED CONSENT FORM SHALL BE AS VALID AS THE ORIGINAL

Revised 7/30/2025