**CEO Early Childhood Services**

**St. Catherine’s Consent Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature indicates that I consent for CEO’s staff to make a referral to St. Catherine’s Child and Family Treatment Support Services and Home and Community Based Services for my child and/or family.

I understand that someone from St. Catherine’s will be contacting me to discuss this referral and I give permission for St. Catherine’s staff to share information about the referral with CEO Staff.

I give CEO’s staff permission to discuss the following items with St. Catherine’s staff:

* Referral Information
* Special Education Information
* Classroom Observation by St. Catherine’s staff if needed
* Screening Results
* All other information regarding my child’s needs

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_