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

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

The decision to have your child evaluated for special services is very difficult and can feel overwhelming at times. Please, let us help you to make sense of the process. You will be signing a consent form that authorizes CEO-Head Start (specifically your family advocate and myself) to send a written request or contact the Rensselaer County Early Intervention for an evaluation. Once the Early Intervention receives the letter or phone call they will contact you to schedule a time to do a visit. During this visit they will be getting background information on your child, and you will be filling out paperwork with them. Included in this packet is information on your rights as a parent through the process. Family Advocates also have copies as well if you any questions. You can also access it on the web: <http://www.health.ny.gov/publications/0532.pdf> . At this time the Early Intervention Service Coordinator will provide you with a list of approved evaluators, you will need to pick a provider of your choice to perform the developmental evaluation (Beginnings, Unity Sunshine, or Story Place). The program that you pick to do the evaluation will contact you to schedule a time and place for the evaluation. A team of professionals will then come to your home or visit the child on-site. The evaluation is going to look at certain areas of your child’s development such as:

* Cognitive (the child’s learning style)
* Self- help skills (how the child can adapt to his surroundings and what they can do for themselves)
* Social/emotional (how the child interacts with those around them)
* Fine motor (how the child uses their small muscles, pre-writing, puzzles)
* Gross motor (how the child uses their large muscles running, jumping )
* Receptive Language ( what a child understands )
* Expressive Language ( how a child expresses themselves)
* Pragmatic Language- (how the child puts words together)

After the evaluation is complete, the evaluation team will write a report that outlines their findings and will include suggestions if any for your child. Once the report has been completed the evaluation team will then mail copies of the evaluation report to the appropriate places. If services are needed an IFSP (Individual Family Service Plan) meeting will be scheduled with you, the providers and Head Start staff. Decisions that are made regarding the services will be developed into an IFSP. This is a plan of goals to enhance your child’s development. If you have any questions or concerns along the way feel free to contact your Family Advocate or myself at 272-6012 ext.220.

Sincerely,

Christina O’Brien

Christina O’Brien

Preschool/Disabilities Specialist

**Parent Consent**

This release of information allows both the written and verbal exchange of information between the CEO-Early Childhood Services and the designated agencies below. (This includes Evaluations, IEP’s and Invitations to all CPSE/ IFSP meetings held.)

TO: E.I. Coordinator /CPSE Chair/ School District \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evaluating Agency and / or Service Provider of Parent’s Choice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CEO-Head Start Contact Person: Christina O’Brien

Preschool/Disabilities Specialist

CEO – Early Childhood Services

2328 Fifth Avenue

Troy, NY 12180

[clobrien@ceoempowers.org](mailto:clobrien@ceoempowers.org)

Tel. # 272-6012, Ext. 220

Re. Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent(s)/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Center and Classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Guardian Signature) (Date)

**Rensselaer County Department of Health**

**Early Intervention Program Referral Form**

**Child’s Information:**

Date of Referral:\_\_\_\_\_\_\_\_\_

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First M.I.

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foster Child: Yes\_\_\_ County of Origin (fiscal)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information**:

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reasons for Referral: (Please be Specific)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral Source:**

Name/Contact: Christina O’Brien

Agency: CEO Rensselaer County Head Start

Address: 2328 5th Ave. Troy, NY 12180

Phone #: 272-6012 ext. 220

**Consent to Release Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for Christina O’Brien,

(Parent/Guardian’s Name)

Special Services Manager, to obtain information regarding my child,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Information may be obtained from

(Child’s Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and may include (please initial below):

(Service Provider/ School District)

\_\_\_\_\_\_\_\_\_\_ Child’s IFSP/IEP

\_\_\_\_\_\_\_\_\_\_Information to Early Head Start/Head Start Staff

\_\_\_\_\_\_\_\_\_\_Obtain Therapy Notes

\_\_\_\_\_\_\_\_\_\_Release Child’s Evaluation

Please mail or fax a copy to:

Christina O’Brien

Preschool/Disabilities Specialist

2328 5th Ave

Troy, NY 12180

W: (518)272-6012 ext: 220

clobrien@ceoempowers.org

**This consent is valid from the date of signature; unless I notify a CEO staff member in writing that I no longer want this consent to be active. Effective until August 2024.**

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_