



SCREENING/ASSESSMENT CONSENT FORM

Please do not list children older than 5 years old

I, _____ give my permission for the child(ren) listed below:
(please print)

Name _____	Birthdate _____	SS# _____	Child Care Provider _____
Name _____	Birthdate _____	SS# _____	Child Care Provider _____
Name _____	Birthdate _____	SS# _____	Child Care Provider _____
Name _____	Birthdate _____	SS# _____	Child Care Provider _____
Name _____	Birthdate _____	SS# _____	Child Care Provider _____
Name _____	Birthdate _____	SS# _____	Child Care Provider _____
Name _____	Birthdate _____	SS# _____	Child Care Provider _____

To be observed and to receive a developmental screening/assessment which may include vision, hearing, speech, language, motor, social, emotional and developmental skills according to Florida Office of Early Learning and ELCAC guidelines. I understand that upon completion of the screening/assessment, the results will be shared with me.

Parent/Guardian Signature _____ Date _____

For more information, contact:
Hailey Rowell, Child Services Specialist

Phone: (352) 375-4110 ext. 135
Warm Line: (352) 375-4087
Fax: (352) 335-1429
hrowell@elcalachua.org