H 5
EIP-CONS-2

NYC EARLY INTERVENTION PROGRAM

PARENTAL CONSENT FOR EVALUATION

Child's EI ID No.: _____ Child's DOB: ____/____/____

Child's Name: _____
Last First

Date of Referral____/____/____

Dear Early Intervention Official Designee:

I authorize the evaluation of my child by **Cooper Kids Therapy Associates**
Name of evaluation site
early intervention services. I understand that several people will be involved in the process to determine whether my child is eligible for services. I also understand that this evaluation site will coordinate the evaluation process and is the only agency that is authorized to arrange an Early Intervention evaluation.

I have been informed that I will be involved in my child's evaluation and Individualized Family Service Plan (IFSP) planning, that I will receive the results of all evaluations and that a copy of all evaluations will be forwarded to the NYC Early Intervention Program to assist in the determination of service needs.

If you request a copy of the evaluations sent to your child's Health Care Provider, please complete the name and address below:

_____
Name & address of Health Care Provider

_____ Date: ____/____/____
Signature of Parent/Guardian

_____ Date: ____/____/____
Signature of Evaluation Site Representative