

Dear Parent/Guardian,

The Massachusetts Department of Early Education and Care (EEC), Early Childhood Mental Health Consultants (ECMHC) @ JRI's Early Childhood Training and Consultation Program (ECTC), and _____

(Name of the Childcare Program that your child is attending).

are working together to prevent, identify, and reduce the impact of behavioral and emotional distress upon young children through the use of on-site early childhood mental health consultation and mentoring. In addition, this work includes training and coaching in order to strengthen program leaders, and to strengthen the capacities of administrators and educators capacities to reflect, problem solve, and be effective in their roles to identify risks and prevent or reduce social-emotional and behavioral concerns that might arise.

As part of a broader comprehensive statewide system of mental health supports for children and families, EEC aims to provide a statewide system of ECMHC services. The consultation services funded through this grant are designed to provide support and guidance to programs, educators, and families to address the developmental, social and emotional, and behavioral challenges of infants and young children that will support healthy development, reduce the suspension and expulsion rate in early education and care settings, and promote school success.

The Consent Form below requests your permission to share information, which is not considered personally identifiable information, to EEC in an aggregate format in order for EEC to understand the effect of such services and to provide information on the much needed services for social emotional services supports for children and families.

The Consent Form also requests your permission to share the data with other agencies of the Commonwealth of Massachusetts. The data to be shared will not be connected to a child, classroom, or program. **Please note that we will combine (aggregate) the data of many children and will not identify any specific individual child.** All personally identifiable linked to a specific child **will be confidential to ensure the privacy of your child and you.** If you do not wish to have any information shared, you may decline this option. Declining this such option will have no impact upon child's early care and education program's ability able to request support through the Early Childhood Mental Health Consultation, and no information will be shared.

If you choose to participate in the Early Childhood Mental Consultation Supports through your early care and education program, please complete the Consent Form below. Thank you!

Early Childhood Mental Health Consultation (ECMHC) Family Consent Form

Child's Name: _____

Child's D.O.B _____

Childcare Program Name: _____

Consultant's Agency: JRI's Early Childhood Training and Consultation Program

Please read the text below and check the box to indicate whether you permit your child to participate in the Early Childhood Mental Health Consultation Supports:

(Please check off one box)

1. By checking this box, I acknowledge that I have read the information provided by the Department of Early Education and Care (EEC) about the Early Childhood Mental Health Consultation Supports and:

- **I agree** to have non-identifiable information entered into the ECMHC reporting database, and
- **I agree** to have non-identifiable information shared with the Commonwealth of Massachusetts, and any of its designated agents or assigns, for the purposes of state-wide data collection that reviews only at aggregated data to determine need for future trainings for early childhood professionals, and policies.

2. By checking this box, I acknowledge that I have read the information provided by the Department of Early Education and Care (EEC) about the Early Childhood Mental Health Consultation Supports and:

- **I do agree** to have my child's non-identifiable information entered into the ECMHC reporting database, and
- **I do not agree** to have my child's non-identifiable information shared with the Commonwealth of Massachusetts and any of its designated agents or assigns.

3. By checking this box, I acknowledge that I have read the information provided by EEC about the Early Childhood Mental Health Services, and I **decline** to have my child(s) data entered in the ECMHC database.

Name of Parent or Guardian

Date

Signature of Parent or Guardian



Department of
Early Education and Care

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