Justice Resource Institute

Early Childhood Training & Consultation Program

CONSENT TO RECEIVE SERVICES

Child's Name: _____ Date of Birth: _____

Parent/ Guardian: _____

Home Address: _____

Parent/ Guardian Contact #: _____

Parent/ Guardian E-Mail Address: _____

Parent/ Guardian Preferred Contact Method (Please check all that apply) ___ Phone ___ Email ___ Text

Child Care Program Name: _____

Child Care Program Contact #: _____

I give my permission for JRI's Early Childhood Training &Consultation Program (ECTC) consultant to provide some or all of the following services at the child care program listed above:

1. Virtual / In-Person Observation of my child in the school or childcare setting.
   *** Please note that the observation will NOT be recorded. ***
2. Consultation to the teaching staff
3. Modeling strategies that support my child's participation in activities
4. Making recommendations for ongoing services
5. Maintain my child's ECTC record in a confidential file

I give permission for ECTC to communicate with the following individuals and/or agencies:

1. Name of your child's current Child Care Program: _____
2. Name of Pediatrician: _____
3. State/government agencies servicing your family: _____
4. Name of Child's Therapist/Counselor / Agency: _____
5. Name of Public School (if applicable): _____
6. Other: _____

I understand that non-identifiable data will be provided to EEC in an aggregate format to assist in understanding the effects of ECMHC and to provide information on the needed social-emotional supports. The data shared will NOT be connected to my child or their classroom.

I also understand that I may revoke this consent to receive services at any future time.

_____ _____

Parent/ Guardian Signature Date

*** This Consent to Receive Services is valid for one year from date signed above. ***