**KINDERGARTEN SCREENING CONSENT FORM - STUDENT**

Dear Parent/Guardian,

As part of the Kindergarten Screening Program, Learning Services staff will be conducting screenings at your child’s school. Screenings are conducted to identify difficulties children may having in relation to speech and hearing, vision, occupation (play) and behaviour. These screenings may be conducted by a Speech-Language Pathologist, Hearing and Vision teacher, Occupational Therapist and/or District Behaviour Interventionist.

**IF YOU DO NOT CONSENT** to this program, please complete the section below and return to your child’s school at your earliest convenience.

If you have any questions, please contact Learning Services at 250-624-6776.

Please print clearly.

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| WITHDRAW CONSENT TO SCREENING |
| I **DO NOT** consent to my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ taking part in the Kindergarten Screening Program.  FIRST AND LAST NAME  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/guardian phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

It is understood that this authorization is valid for one calendar year.