Agreement for ECDC Therapy Screening

I request and give my permission for my child,_____(Please print child's name), to participate in a developmental therapy screening at my child's school conducted by Light of Mine, PLLC pediatric therapy team. I understand that information regarding recommendations will be released to me (parent or guardian) and the school staff/educators.

I give consent and authorize the Light of Mine therapist discuss my child's medical history/treatment with the school staff/educators.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Printed Name of Parent Phone Number

_____ _____

Child's Date of Birth Email Address