



**EARLY INTERVENTION THERAPY SERVICES**  
**Kiwanis Hilton Children's Centre**  
 4325 Neill Street  
 Port Alberni, B.C. V9Y 1E5  
 Fax: 250-723-7349



Phone: 250-723-1117

Phone: 250-723-1118

**CONSENT TO RECEIVE SERVICES**

I, the undersigned parent/legal guardian of \_\_\_\_\_,

(Date of Birth) \_\_\_\_\_, do hereby authorize:

(Island Health)  Speech-Language Pathology      (Outreach Therapy)  Occupational Therapy       Physiotherapy

to provide service(s) for the above named child.

These services may include assessment, recommendations and intervention.

I understand that:

- assessment can involve parent/legal guardian/caregiver interview, play-based observations and formal standardized measures. I further understand that all results and recommendations will be shared with me.
- any intervention plan will be designed by the therapist, in collaboration with me, to meet the individual needs and strengths of my child and family within the parameters of the service.
- this is an integrated team including Preschool Speech Services (Island Health), Occupational Therapy (Outreach Therapy) and Physiotherapy (Outreach Therapy) and that all members of the team will have access to my child's electronic file.
- participation in these services is voluntary and I may withdraw from services at any time.
- admission to services will be at the discretion of the therapist. I further understand that discharge from services will take place on the recommendation of the therapist or by my request.
- if I am not present for a therapy session, I am responsible to pick up my child promptly at the session's end. If I am unable, my designated emergency pick up will be contacted and identification requested before child is released. If this step is unsuccessful, the Ministry of Children & Family Development will be contacted and my child released into social worker custody.

I agree to notify the therapist(s) involved if there is a change in family contact information, emergency contact and guardianship status or custody arrangements for my child.

\_\_\_\_\_  
 Name of Parent / Legal Guardian (please print)

\_\_\_\_\_  
 Relationship to Child

\_\_\_\_\_  
 Signature of Parent / Legal Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Name of Witness (please print)

\_\_\_\_\_  
 Signature of Witness

*Note: This consent expires upon discharge from service or if guardianship changes.*