CONSENT FOR REFERRAL or EVALUATION

Child's Name: _____ Center/Classroom: _____

Parent's Name: _____ Phone Number: _____

During screenings given to all Head Start children, your child's screening indicated potential concerns in one or more area(s). Further evaluation and/or referral is needed in order to plan an appropriate education program for your child and increase school readiness. Below is a short description of the evaluation(s), with the area to be tested. The results of an evaluation will assist in determining if your child is eligible to receive special services. Results of evaluations will be shared with you. **Head Start wishes to evaluate the areas checked below, or refer to your child's school or other agency for further evaluation.**

____ **Speech/Language:**	Speech skills (including articulation, voice fluency, and oral-motor) and/or receptive and expressive language skills and abilities (including phonology, morphology, syntax, semantics and pragmatics.
____ **Intellect/Cognitive:**	Individually administered assessment of child's learning abilities, development, and cognitive functioning.
____ **Adaptive/Behavior:**	Assessment of child's general behavior in the school home and community settings.
____ **Gross/Fine Motor:**	Assessment of gross and/or fine motor skills and abilities in relation to educational needs status (may include rating scales, behavioral observations, interviews and personal inventories).
____ **Perceptual/Process:**	Child's abilities to perceive and/or process information through visual, auditory, and sensorimotor means.

____ We recommend that your child be referred for **speech** evaluation.

____ We recommend that your child be referred to the **public school** for further evaluation.

____ We recommend that your child be referred for **counseling** services.

PRIOR TO EVALUATION:

Please initial next to the applicable statement and sign /date below.

____ **I give permission** to have my child evaluated by a Head Start **speech** pathology consultant.

____ **I give permission** for my child to be referred for further evaluation, testing and services through the **public school**.

____ **I give permission** for referral for **counseling** services to _____.

Parent/Guardian: _____ **Date:** _____

Health Insurance Provider: ☐ SoonerCare (Medicaid) ☐ Other_____

If parent marks "Other"; referral list provided by _____