**PARENT/GUARDIAN PERMISSION FOR THE VERMONT SENSORY ACCESS PROJECT SERVICES AND**

**CONSENT TO THE RELEASE OF PERSONALLY IDENTIFIABLE INFORMATION**

I am the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I give permission for my child’s IEP team and school:

* To request and receive consultation services from the Vermont Sensory Access Project (VSAP) and related UVM Personnel to support planning and implementing of my child’s IFSP/IEP and school program.
* To exchange information from my child’s educational records with VSAP for use during the consultation and related planning and implementation of the IFSP/IEP

I give permission for the Vermont Sensory Access Project (VSAP):

* To consult internally with UVM personnel in rendering the consultation services requested by my child’s IEP/IFSP team.

I understand that:

* VSAP services may include such services as observation of my child in educational settings (including the home, if my child is receiving IEP/IFSP services there), participation in team meetings, talking with me and with school staff and service providers about my child’s needs, and providing training and/or recommendations.
* There is no cost to my family for these services.
* Confidentiality requirements will be observed by the school and VSAP.
* VSAP services will continue on an ongoing basis, unless the team/school district no longer requests VSAP consultation.
* I may revoke this consent in writing at any time in the future if I no longer wish to have the VSAP consultant involved with respect to my child’s IEP and/or educational programming.

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Print Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language used in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School District Name/EI Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional Consents

1. Photographs and recordings for Use by VSAP. I consent for VSAP and my child’s school to photograph, record, audio and/or video my child to assist in determining and providing IEP/IFSP recommendations and implementation. These items will only be shared with VSAP members and team members involved in planning and/or implementing my child’s programming

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian signature

2. Use of e-mail. I consent to the use of e-mail for confidential correspondence between VSAP, members of the IEP/IFSP team, and me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian signature

3. Consent to Release of Medical and/or Other Third Party Information

To assist VSAP and my child’s school educational team in planning and implementation of services for my child, I give permission to VSAP and my child’s IEP Team/IFSP team to disclose educational records and information regarding my child, to the individual(s), agency(ies), or organization(s) named below, and for person(s)/organization(s) named below to disclose information and/or records regarding my child to VSAP and IEP/IFSP team.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) of Person, Agency or Other Third Party(ies):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

VT Sensory Access Project

Confidential Fax: 802-656-3636