

**DEVELOPMENTAL SCREENING CONSENT FORM**

The first five years of life are very important for your child’s future success in school and life. It is important to ensure that a child’s development stays on track during this period. Completing regular screenings is the best way to ensure that your child reaches their highest potential.

**Child’s Name: Child’s Date of Birth: Number of weeks premature:**

**CONSENT TO SCREEN WITH APP AND (IF APPROPRIATE) REFER:**

Please mark the space below choosing whether you give consent to participate in our MMI screening program:

I have read the information provided about screening and I DO wish to have my child participate.

I have read the information provided about screening and DO NOT wish to have my child participate.

**CONSENT TO SHARE SCREENING RESULTS WITH PRIMARY HEALTH CARE PROVIDER:**

Please mark the space below choosing whether you give consent to share your child’s screening results with your child’s primary health care provider:

I understand the importance of sharing my child’s screening results with their primary health care provider and give consent for my early childhood program to share my child’s results with the following provider(s):

Primary Health Care Provider Information:

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I DO NOT wish for my early childhood program to share my child’s screening results with my child’s primary health care provider.

**Parent or Guardian Name Signature Date**