

PARENT RELEASE
(MEMBER DISTRICTS ONLY)

This form is to be attached to the Developmental History Questionnaire. Please complete all portions of this referral packet. If you are in need of assistance, please contact your child's school.

_____ (Student's name) _____ (Referring District)

PARENTS MUST ACCOMPANY THE STUDENT TO R.E.A.D.S. ON THE INITIAL VISIT.

I, as a parent or guardian, hereby give consent for R.E.A.D.S. to conduct any *medical* and/or *psychoeducational evaluation(s)* on the above named child. I understand that the results of these evaluations will be shared with the public school named above. I give consent for the R.E.A.D.S. staff to review any school records as deemed necessary to carry out the requested evaluation(s). I also give the READS staff permission to take a Polaroid photograph of my child, to be included in the student's file for the purpose of identification.

_____ (Date) _____ (Signature) _____ (Relationship)

In addition, I give permission to the staff at R.E.A.D.S. to contact my family physician for relevant medical information.

Physician name: _____
Street Address: _____
City/Town: _____
State/Zip Code: _____
Phone: (____) _____

_____ (Date) _____ (Signature) _____ (Relationship)

I give my permission to the staff of R.E.A.D.S. to contact my child's most *recent therapist* or *out-of-school counselor* (if any) named below in the interest of obtaining relevant information.

Therapist or Counselor: _____ Street Address: _____
City/Town: _____ City/Town: _____
State/ Zip Code: _____ State/ Zip Code: _____
Phone: (____) _____ Phone: (____) _____

_____ (Date) _____ (Signature) _____ (Relationship)

MEDICAID INFORMATION

If your child is eligible for Medicaid, *please* complete all of the information on this form and *bring* your *Medicaid or Mass Health card* with you on your first visit.

If the child's name is spelled incorrectly on the Medicaid card, please write it on this form identical to the spelling on the card and then make a note on the bottom of this form indicating the correct spelling.

_____	_____	_____
(Last Name)	(First Name)	(Middle Initial)

- - - - -		
(Card Holder's Number)		

_____	_____	_____
(Student's Number)	(Eligibility Date: From	To)

_____	()	_____
(Medicaid Office Town)		(Medicaid Office Phone)

My child is not eligible for Medicaid. (Please check if your child is not on Medicaid.)