Neuropsychological Consulting Services

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CONSENT FOR SCHOOL OBSERVATION

Patient Name_____ Date of Birth_____

Address_____

Phone_____

I hereby authorize Neuropsychological Consulting Services to:

_____ Contact my child's school or other facility to schedule an observation and/or evaluation of my child in the school setting and to observe or evaluate my child at school or other facility.

_____ Talk to educators/adults at the school or facility where the observation and/or evaluation takes place, to gather more information about my child's abilities and areas of weakness.

_____ (name of school or other facility)

_____ (name of contact person)

_____(address of school or facility)

_____ (phone number)

This authorization may be revoked at any time except to the extent that action has already occurred in reliance thereupon. This authorization shall be valid for (180) days unless otherwise specified.

Signature of parent/guardian_____ Date_____

Relationship to patient_____