YUKON FIRST NATION EDUCATION DIRECTORATE

Suite 300 – 204 Black Street
Whitehorse, Yukon Y1A 2M9

T: 867.667.6962
F: 867.668.6189

E: admin@yfned.ca
www.yfned.ca

CONSENT FORM FOR RELEASE OF PERSONAL INFORMATION

I am the parent/guardian of: _____

I authorize the following organization(s):

☐ Government of Yukon, specifically,

- ☐ Department of Education
- ☐ Health and Social Services
- ☐ Other (please specify): _____

☐ First Nation (please specify): _____

☐ Other:

- ☐ Boreal Clinic
- ☐ Child Development Center
- ☐ Joy Vall, Occupational Therapy
- ☐ Council of Yukon First Nations
- ☐ Klondyke Medical Clinic
- ☐ Daycare _____
- ☐ Other (please specify): _____

to release all written and electronic information, records and documents relating to my child's personal information to the Yukon First Nation Education Directorate and, where appropriate, communicate about my child with the Yukon First Nation Education Directorate (the "**Shared Information**").

I understand that I can withdraw or revoke my consent under this Form, at any time, by providing written notice to the Yukon First Nation Education Directorate and, where possible, the Yukon First Nation Education Directorate will return the Shared Information and delete any electronic copies.

The Yukon First Nation Education Directorate will not share, circulate or forward any Shared Information to any other person or entity without your written permission.

Parent/Guardian Name: _____
Contact Information: _____
Relationship to the Child: _____

Parent/Guardian Signature: _____

Date: _____

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CONSENT FORM – Mobile Therapeutic Unit (MTU)

I, _____ (parent/guardian's name) agree to allow my child _____ (child's name) to receive Occupational Therapy, Speech Language Pathology, Counselling and/or Vision Specialist services from the YFNED Mobile Therapeutic Unit.

I understand that services will be provided either at my child's school, community and/or at home. By signing this form, you are providing consent and agreement of:

- The OT/SLP/Counsellor/Vision Therapist will complete an initial observation of your child's skills and abilities and challenges. They will always consult with you first once the referral is received, and ask you how you would like to go forward with additional services.
- The OT/SLP/Counsellor/Vision Therapist will always work together with you and your family to best support your goals/priorities for your child and family.
- Information such as goals/plans, assessment results and summary reports will always be shared with you. The therapist may also share your child's information with other professionals working with your child with informed consent, otherwise confidentiality will be respected.
    - There are a few legally mandated exceptions to confidentially, as we are legally required to report to relevant agencies if:
        - a student is in immediate danger to self or others (e.g., in the case of suicide or violent assault);
        - notification of Child Protective Services in cases of suspected child abuse, neglect, or maltreatment; and
        - in legal cases, clinicians or clinical records may be subpoenaed by the court.
- The OT/SLP/Counsellor/Vision Therapist will be corresponding via emails, face to face, text, and/or telephone to communicate with your child's teacher and/or other people involved with your child's learning, including other allied health professionals.

The OT/SLP/Counsellor/Vision Therapist may take photos and videos of my child performing therapy activities to record their progress. *Please Note: If you do not wish your child to be photographed or videotaped, please advise of this immediately and before programming begins.

I understand and provide the OT/SLP/Counsellor/Vision Therapist with my consent regarding all of the above.

Signature: _____ Date: _____