Wild Rose Public Schools

Parent Consent for:

WRPS Speech-Language Pathology

Date of referral (yy/mm/dd): ______________________________

Student Information:

Child's Legal Name: ______________________________

Date of Birth (yy/mm/dd): ______________________ Grade: __________

Student's Address: ______________________________

Parent/Guardian: ______________________________ Home phone #: __________

Business phone #: __________________ Extension: __________

I understand it is my responsibility to advise the school in writing of my withdrawal of any portion of, or all of this written consent.

Name of consenting person (please print)	Relationship to child
Signature of consenting person	Date
Name of consenting person (please print)	Relationship to child
Signature of consenting person	Date

School Information - if you have any questions or require clarification please contact:

School Contact: ______________________________

Phone: ______________ Fax: ________________ Email: ______________________

To be able to provide educational support services to your child, we need to ask you for some personal information.

Pursuant to the School Act, the Student Record Regulation and the Freedom on Information and Protection of Privacy Act, the School Jurisdiction may disclose to other professionals involved in your child's program, relevant information in your child's Cumulative Record.