Wild Rose School Division

Parent Consent for:

Educational Psychological Assessment
WRSD Personnel

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.