

Learning Disability Specialist Teacher and/or Assistive Technology Support Worker Services Parent/Guardian Consent

Student's Name: _____ Date of Birth (m/d/y): _____

School: _____ Grade: _____ School Year: _____

**Please note consent for services is valid for the current school calendar year only.*

South Shore Regional Centre for Education LD Specialist Teacher provides support for students diagnosed with a Learning Disability (LD)/Specific Learning Disorder (SLD). Service may include time spent with the child (in or out of the classroom) and/or consultation with the child, parent/guardian, and school team.

This referral is part of the ongoing efforts of the Student Planning Team to identify and meet your child's needs at school. It is important for you to understand that participation in the above supports is voluntary. You and/or your child have the right to decline or discontinue this process at any time. You will be provided with a copy of any report(s) that are produced from an assessment, if conducted.

Consultation with your child and school may include:

- Discussion about their LD/SLD and learning style
- Encouragement of self-advocacy and independence
- Recommendations and support of program adaptations (*including technology support)

Parent(s)/Legal Guardian(s) please complete:

☐ I/We the undersigned, hereby affirm that I am/we are the parent(s)/legal guardian(s) of _____ (student's name) and have the authority to make decisions on their behalf.

**Please note: If there is a shared custody arrangement, both parents will be required to sign this consent form for the service to take place.*

☐ I/We give full and informed consent to _____ (student) receiving the above indicated service, and that the team referral, parent/guardian consent, and assessment report (if completed) will be uploaded in the student's permanent electronic confidential file (TIENET). I understand that this information will be discussed at the Student Planning Team meetings and may be used to program for my child and that I may withdraw consent from this service at any time.

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

OR

☐ I/We **do not** consent to _____ (student) receiving the above indicated service.

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

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Assistive Technology Support Worker

*Assistive Technology Support Workers (ATSWs) provide follow up support based on the recommendations of the LD Specialist Teacher. The Assistive Technology Support Workers may work one on one or in small groups with your child to ensure they are familiar and comfortable with the recommended technology.

☐ I/We consent to _____(student) receiving the above indicated service.

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

OR

☐ I/We **do not** consent to _____(student) receiving the above indicated service.

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____