



Children's Development Centre

1546 Bernard Avenue, Kelowna, BC V1Y 6R9

Phone: 250-763-5100 | Fax: 250-862-8433

Date Received: for office use only:

Plagiocephaly-Torticollis Parent Consent Form

Child Information (please print)

MSP Personal Health Number: Child's First Name: Child's Last Name:

Date of Birth: (DD/MM/YYYY) Child's Gender: CLIENT CODE: for office use:

Name of Person(s) child resides with (First and Last):

Relationship to the child:
Both Parents, the child refers to you as:
Single parent, the child refers to you as:
Maternal Grandparent(s), the child refers to you as:
Paternal Grandparent(s) the child refers to you as:
Foster parent(s): the child refers to you as:
Other caregiver(s): the child refers to you as:

Home Address: City: Postal Code:

Email: Home phone number: Cell Phone number:

Are you the legal guardian for this child?
Both Parents
Mother Only
Father Only
Maternal Grandparent(s)
Paternal Grandparent(s)
MCFD SW (name)
Other:
If applicable, please provide a copy of any legal custody document regarding this child.

Parent / Guardian Priorities – Reason for referral

What are the most important issues that you hope will be addressed with your child?

Cultural Information (optional)

Do you wish to self-identify your child as:
First Nations/Aboriginal Ancestry
Metis
Other self-identified culture?
If yes, please describe:

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Additional Information	
Primary Language Spoken at Home: <input type="checkbox"/> English <input type="checkbox"/> Others: (please list)	Are you comfortable communicating in English? Spoken: <input type="checkbox"/> Yes <input type="checkbox"/> No Written: <input type="checkbox"/> Yes <input type="checkbox"/> No Would an interpreter be helpful?

Birth Information and Medical History

Pregnancy description:
 Healthy, with no complications Complications (*please provide medical and health details*):

Delivery: Vaginal Caesarean Gestational Age _____ weeks

Birth weight (*please indicate pounds or kilograms*): _____

Was there any known fetal exposure to alcohol: No Yes

Was there any known fetal exposure to prescription drugs: No Yes (*please provide details*):

Was there any known fetal exposure to non-prescription drugs: No Yes (*please provide details*):

Does your child have ongoing health issues: No Yes *If yes, please provide details below:*

Does your child use medication? No Yes (*please specify*) _____

Has your child been seen by a specialist? No Yes _____

Does your child have a diagnosis? No Yes _____

Has your child been hospitalized at any time? No Yes _____

Does your child have any allergies? No Yes _____

Additional details:

Hearing *If not applicable, please skip this section*

Was hearing tested at birth? No Yes *If yes, were any of the following recommended:*

- follow-up and/or monitoring No Yes
- a hearing device No Yes

History of ear infections? No Yes (*please provide details*):

Vision: *If not applicable, please skip this section*

Has vision been tested? No Yes *If yes, was the following recommended:*

- follow-up and/or monitoring No Yes

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Development Information**Feeding**

Currently breastfeeding: No Yes

Is feeding a concern? No Yes *If yes, please provide details:*

We are attempting to streamline services and work in collaboration with the Feeding and Swallowing Team at Kelowna General Hospital (KGH).

Have you, or will you receive support from the KGH Feeding and Swallowing Team? No Yes

If yes, do you consent to Starbright sharing information with the KGH Feeding and Swallowing Team? No Yes

Large muscle movement (sitting, crawling, walking)

Do you have concerns with large muscle movement? No Yes *If yes, please answer questions below :*

Area of concerns:

How old was your child when s/he began to do each of the following:

Rolling _____ Not Yet Sitting _____ Not Yet

Crawling _____ Not Yet Walking _____ Not Yet

Small muscle movement (fingers, hands) *If not applicable, please skip this section*

Do you have concerns around fine motor development? No Yes *if yes, please describe:*

Other services

Does your child receive other complementary services (e.g. speech, physiotherapy, naturopathy, massage, chiropractor, acupuncture, reflexology, etc.) from other service providers?

No Yes *If yes, please provide details:*

Name of Centre:

Contact person/title

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Contact person/title

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CONSENT FOR SERVICE

I understand that when this request for service is received, I will give consent to be contacted by someone at Starbright Children's Development Centre by phone and/or email.

I understand that services are provided at our Centre, at home, or via tele-health, based on child or family circumstances.

I understand that if sessions are being conducted by tele-health, this includes treatment using interactive audio, video, or data communications and that:

- I am responsible for providing the necessary computer, telecommunications equipment and internet access for the tele-health sessions,
- I am responsible for the information security on my computer, and
- I am responsible for arranging a place/space with sufficient lighting and privacy for my tele-health session.

- ◆ If you are not self-referring, do we have your permission to contact the referral source? No Yes
- ◆ Do you agree to have practicum students observe and/or participate in therapy? No Yes
- ◆ Do you agree that Starbright Children's Development Centre may use audio/visual technology (for the purpose of recording therapy, assessment and progress only)? No Yes
- ◆ Would you like to receive Centre information such as newsletters and surveys? No Yes
- ◆ In the event of an emergency, do you agree the Centre should take whatever action is deemed necessary, including the administration of First Aid, to ensure the health, well-being and safety of your child?
 No Yes
- ◆ Are there any other contacts we can call in case of an emergency?
 No Yes *If yes, please provide details:*

EMERGENCY CONTACT NAME	HOME PHONE NUMBER	CELL PHONE NUMBER	RELATIONSHIP TO CHILD

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Starbright Children's Development Centre Consent to Obtain/Release Information:

Please indicate in the columns below all providers for which you give consent

I choose to consent to release information to the following:	I choose to consent to obtain information from the following:	To provide safe and effective services for your child, Starbright staff may need to request information from, and share information with, your child's other service providers. All information is treated as strictly confidential. A copy of this consent will be sent to all persons/agencies when information is requested from them. Starbright reports will be sent to the parent(s) and/or guardian(s).			
		Family Physician	Name	Phone	
		Pediatrician	Name	Phone	
		Preschool/Daycare	Name	Phone	
		Ministry of Children and Family Development	Name of Social Worker		
		Public Health Nurse (IH)	Name		
		Kelowna General Hospital			
		Children and Youth with Special Needs			
		Interior Health Children's Assessment Network			
		Okanagan Ability Centre			
		BC Children's Hospital (Please check all that apply)	<input type="checkbox"/> Neurology <input type="checkbox"/> Orthopedics <input type="checkbox"/> Cardiology <input type="checkbox"/> Genetics <input type="checkbox"/> Epilepsy <input type="checkbox"/> Oncology <input type="checkbox"/> Muscle Diseases <input type="checkbox"/> Bio Chem Disease <input type="checkbox"/> Complex Feeding Team <input type="checkbox"/> Feeding Swallowing Team		
		Sunnyhill Health Clinic (Please check all that apply)	<input type="checkbox"/> Assessment <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Hearing Loss Team <input type="checkbox"/> Visual Impairment Team <input type="checkbox"/> Positioning and Mobility Team <input type="checkbox"/> Complex Developmental Behaviour Conditions		
		Other:			

I authorize Starbright Children's Development Centre to obtain and/or release information regarding my child

Child's NAME: _____, DOB: _____ from the persons/agencies listed above.

I understand and agree that this consent for service (pg 4) and this consent to obtain/release information, will continue to remain in effect until all services provided to my child or children by Starbright Children's Development Centre have ended, or until I have changed this consent. I understand I may request to have my Consent Form updated as information changes.

X _____
 Signature of Legal Guardian Printed Name of Legal Guardian Relationship to the Child

X _____
 Date:

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