



## Physician Notification and Parental Release of Confidential Information Form to the Exceptional Children Preschool Program

Directions: To be completed by the appropriate Primary Care Practice and/or Pediatrician (PCP) and sent to the appropriate Exceptional Children Preschool Program contact. Upon receipt, the school system will contact the family to set up a screen and/or referral meeting. The PCP is encouraged to provide the family with the contact name and number for the receiving school system.

### Child Contact Information

Child Name:	Date of Birth:	Gender: M F
Home Address Street:	City:	State: Zip:

### Parent/Guardian Contact Information

Parent/Guardian: _____ Street: _____ City: _____ State: <u>NC</u> Zip: _____ Email: _____	Primary Language: _____ <input type="radio"/> Interpreter is needed due to English as a second language  Ethnicity: _____	<input type="radio"/> Interpreter needed due to deafness or a hearing impairment or other accommodation(s) due to disability (please specify):  _____
Home Phone: ( ) _____	Work Phone: ( ) _____	Cell Phone: ( ) _____

### Physician Contact Information

Physician Name:	Address:	Office Phone: Office Fax:
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### Reasons for Notification to Preschool Program (Check all that apply)

Suspected delay in: <input type="radio"/> Motor skills <input type="radio"/> Cognitive skills <input type="radio"/> Social-Emotional skills <input type="radio"/> Communication skills <input type="radio"/> Behavioral skills <input type="radio"/> Speech-Language skills	<input type="radio"/> Autism <input type="radio"/> **Screen tool (please attach) <input type="radio"/> ASQ <input type="radio"/> PED <input type="radio"/> MCHAT <input type="radio"/> ASQ-SE	<input type="radio"/> Identified condition or diagnosis <input type="radio"/> Specific concerns  _____  _____
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**If parent(s) has agreed to pursue services from the Exceptional Children Preschool Program and is prepared to provide parental consent for release of confidential information at this time, please complete the information below.**

<b>Specific records to be released to and/or received from this office (please check):</b> <input type="checkbox"/> <u>School system evaluation results</u> <input type="checkbox"/> <u>Vision screening/evaluation results</u> <input type="checkbox"/> <u>Hearing screening/evaluation results</u> <input type="checkbox"/> <u>Developmental screening results</u> <input type="checkbox"/> <u>Health screening results</u> <input type="checkbox"/> <u>Social Emotional/ Behavioral Health Screening results</u> <input type="checkbox"/> <u>Other</u>	<b>Purpose of the disclosure:</b> <ul style="list-style-type: none"> <li>▪ <u>Notification for preschool exceptional children program services</u></li> <li>▪ <u>Educational/instructional planning</u></li> </ul>	<b>Party to whom the disclosure will be made:</b> School system name: _____  School system in which the private school is located: _____
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I give informed parental consent to disclose the confidential records listed above for the purpose(s) listed above, and to the part listed above:

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Unless otherwise revoked, this authorization expires one year from the date of signature

I request a copy of the confidential records disclosed.

**\*\*Notation:**

ASQ: Ages and Stages Questionnaire

ASQ-SE: Ages and Stages Questionnaire for Social and Emotional Development

MCHAT: Modified Checklist for Autism in Toddlers

PED: Parent's Evaluation of Developmental Status

To be completed by school system staff  
 Date received by school system:  
 Follow-up communication with family: