



## True Balance Counselling

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### Parental Informed Consent for Psycho-Educational Assessments

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**\*\*Please initial all lines and sign and date at the bottom\*\***

\_\_\_\_\_ I have read the Understanding Psychoeducational Assessment Information sheet and have had sufficient time to consider it carefully, and ask any questions I have.

\_\_\_\_\_ I understand that a Psychologist from True Balance Counselling will be completing my child's assessment.

\_\_\_\_\_ I understand Psychoeducational assessments may involve school visits, classroom observations, one-on-one assessment, review of school records and previous assessment reports, parent/teacher/student questionnaires, and follow-up with school personnel and parent/guardian at the conclusion of the assessment.

\_\_\_\_\_ I understand I will be provided a copy of the assessment report when it is complete at the follow-up meeting and a second copy will be placed on the school file (if contracted through the school to complete the assessment). All assessment materials will be kept by the Registered Psychologist providing the assessment for 10 years after the assessment is complete.

\_\_\_\_\_ I understand the nature of the Psychoeducational Assessment process, including the risks and benefits.

\_\_\_\_\_ I understand my rights as a parent to revoke this consent at any time up until the assessment is complete.

\_\_\_\_\_ I understand this consent for one year from the signing date

\_\_\_\_\_ I understand the Registered Psychologist completing this assessment may have administrative support in the assessment process and scoring of assessment materials. These individuals have signed a detailed confidentiality agreement prohibiting them from disclosing any information regarding the assessment.

I agree to have my child participate in the Psychoeducational Assessment process as outlined above and in the Understanding Psychoeducational Information sheet. I also agree I am legally authorized to give permission for assessment services and that I am the legal guardian(s) of this child and the parental arrangements are (please check one):

\_\_\_\_ Married/common law with other biological parent    \_\_\_\_ Separated with Sole Custody    \_\_\_\_ Separated with Joint Custody  
\_\_\_\_ Other (please

explain: \_\_\_\_\_

**\*\*Note: in the case of joint custody, both parents' signatures are required\*\***

**This consent form will remain in effect for the duration of the current Academic School Year**

\_\_\_\_\_  
Parent/legal guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/legal guardian signature

\_\_\_\_\_  
Date

## CONSENT FOR SUPERVISION

My assessment is being completed by Allie Borgstrom, a Registered Psychologist 4600, licensed to practice Psychology with the College of Alberta Psychologists. Allie has been a counselling Psychologist since 2016, and is now actively working on expanding her competency to include the domain of formal assessments.

Part of the process of expanding competency requires my Psychologist to engage in supervision to ensure competency. As such information will be shared with the supervising Psychologist for the purpose of supervision. Supervision of assessments can include direct observation of assessments, review of recordings, review of scoring, review of formal reports, and direct observation of meetings. The supervising Psychologist, is Daelynn Takasaki, Registered Psychologist. The supervision process ensures my psychologist is providing the best possible service and that the clients best interests are maintained.

- I consent to my assessment being completed by Psychologist Allie Borgstrom, under the supervision of Daelynn Takasaki, and as such my information being shared for the purposes of supervision.
- I am aware that I am not required to be observed or recorded. Any observation or recording of my assessment will be for training purposes only.
- I can withdraw my permission at any time. My access to assessments through True Balance Counselling will not be affected by my decision to not be observed or recorded.

I have read, understand and agree to the terms of my (or my child's) assessment information being shared for supervision purposes.

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Date

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Supervision

**Psychoeducational Assessment**  
**General Information and History Parent/Guardian Questionnaire**

The following information is important to consider in the assessment process and will be valuable in ensuring the parent/guardian perspective is considered in the assessment. Please complete the following information as best you can and return to the school as soon as possible. Please attach additional pages if you have any further comments or concerns you would like to share.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Name of Parent(s) or Guardian(s) with whom the child resides with and relationship to the child:

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

3. Language(s) spoken in the home: \_\_\_\_\_

4. Has the child had their hearing assessed in the last five years? ☐ Yes ☐ No

5. Has the child had their vision assessed in the past two years? ☐ Yes ☐ No

6. Does the child require corrective lenses/glasses to aid their vision? ☐ Yes ☐ No

7. Does the child have any medical diagnosis/conditions?

*Please list all diagnoses and the name of the medical professional whom diagnosed your child*

8. Is the child currently taking any medications and if so, what medications are they on and when were they prescribed? ☐ Yes ☐ No

If yes, please explain:

9. Were there any complications during pregnancy or birth with this child? ☐ Yes ☐ No

If yes, please explain:

10. Did this child meet developmental milestones (i.e., sitting, walking, talking, etc.) within an average timeframe? ☐ Yes ☐ No

If no, please provide details:

11. Has this child experienced any significant trauma in their lives (i.e., death of a loved one, accident, abuse, etc.)? ☐ Yes ☐ No

If yes, please provide details:

12. Do you have any concerns with any of the following with regards to your child?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Attention/focus     | <input type="checkbox"/> Defiance       | <input type="checkbox"/> Emotional Regulation |
| <input type="checkbox"/> Social Skills       | <input type="checkbox"/> Aggression     | <input type="checkbox"/> Reading              |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> School Refusal | <input type="checkbox"/> Writing              |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Attendance     | <input type="checkbox"/> Mathematics          |
| <input type="checkbox"/> Daily Living Skills | <input type="checkbox"/> Academics      | <input type="checkbox"/> Peers                |

If you indicated concerns in any of the above areas, please provide more specific details below:

13. What are some of your child's interests and strengths?

14. Is there anything else you think I should know about your child?

Completed By: \_\_\_\_\_

Date: \_\_\_\_\_