horizon.ab.ca
P: 403.223.3547
6302 56 street,
Taber, AB T1G 1Z9

In partnership with:

True Balance Counselling

Daelynn Takasaki Registered Psychologist #3420

#3, 704 4th Ave N, Lethbridge, AB T1H 6X4 (403)331-9762 daelynn.takasaki@horizon.ab.ca

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 brochure and have had sufficient time to consider it carefully, and ask any questions I have.

_____ 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. 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 is in effect for the duration of the current school year.

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

_____ I understand that I am agreeing to have my child assessed during the COVID-19 Pandemic and recognize that my child will be meeting with the Psychologist during the pandemic and will take the necessary precautions to ensure everyone (you, the psychologist, your family and other staff and students are safe by ensuring I complete the screening tool provided by your school for symptoms the day of my child's assessment. I will not send my child to the school to be tested if concerns and symptoms are noted during the self-assessment screening and will reschedule with the Psychologist. I am also aware the Psychologist will also complete a self-assessment prior to the meeting and will take extra precautions for sanitizing and safety during the testing.

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

☐ Married to the other biological parent ☐ Separated with Sole Custody with documentation
☐ Separated with Joint Custody (joint custody is assumed if custody documentation has never been completed)
☐ Other (please explain) _____

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

This consent form will remain in effect for one year from the date of signing.

_____ _____
(parent/legal guardian signature) (date)

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?

☐ Attention/focus	☐ Defiance	☐ Emotional Regulation
☐ Social Skills	☐ Aggression	☐ Reading
☐ Anxiety	☐ School Refusal	☐ Writing
☐ Depression	☐ Attendance	☐ Mathematics
☐ Daily Living Skills	☐ Academics	☐ 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: _____