



## **Parent Permission Form for Consultation, Access, Resources and Equipment Support (CARES)**

### **Consent to the Release of Personally Identifiable Information**

I am the parent or legal guardian of:

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I give permission for my child's school team and school:

- To request and receive consultation services from the CARES Team and related UVM personnel to support planning and implementation of my child's school program.
- To exchange information from my child's educational records with the CARES Team for use during the consultation and related planning and implementation of the IEP/504. Additionally, I provide consent for the CARES Team to share information with my child's education team.

I understand that:

- CARES Team services may include such services as observation of my child in educational settings, participation in team meetings, talking with me and with school staff and service providers about my child's needs, and providing training and/or recommendations.
- There is no cost to my family for these services.
- Legal confidentiality requirements will be observed by the school and the CARES Team.
- The CARES Team services will be on-going, unless the CARES Team /school district no longer requests DHHDB consultation or if I revoke consent for the CARES Team services.
- This consent will be in effect for up to three years and may cover multiple school years. However, I also understand that I may revoke this consent in writing at any time in the future by giving written notice to the CARES Team if I no longer wish to have the CARES Team consult with respect to my child's educational programming.

## Additional Consents

1. **Photographs and recordings for Use by Team.** I consent for CARES and my child's school to photograph, record, audio and/or video my child to assist in determining and providing IEP/504 recommendations and implementation. These items will only be shared with CARES, UVM related personnel and team members involved in planning and/or implementing my child's programming.

\_\_\_\_\_  
Date: \_\_\_\_\_  
Parent/Guardian signature

2. **Use of e-mail.** I consent to the use of e-mail for confidential correspondence between the CARES Team, UVM Related Personnel, my child's school educational team, members of the IEP/504 team and me.

\_\_\_\_\_  
Date: \_\_\_\_\_  
Parent/Guardian signature

### 3. Consent to Release of Medical and/or Other Third-Party Information

To assist the CARES team and my child's school educational team in planning and implementation of services for my child, I give permission to CARES and my child's IEP/504 team to receive or disclose health and/or educational records and information regarding my child, to the individual(s), agency(ies), or organization(s) named below, and for person(s)/organization(s) named below to disclose information and/or records regarding my child from/to CARES and the IEP/504 team.

Child's Name:

\_\_\_\_\_  
Name(s) of Person, Agency, or Other Third Party(ies):

- 1) UVM Medical Center Educational Services Program
- 2) UVM Medical Center Ear, Nose and Throat (ENT)
- 3) UVM Medical Center Audiology- Fanny Allen
- 4) UVM Health Network Porter ENT and Audiology
- 5) UVM E.M. Luse Center
- 6) Northwestern Medical Center ENT and Audiology
- 7) Northwest Hearing Services
- 8) Better Living Audiology

- 9) Brattleboro Hearing Center
- 10) Rutland Regional Medical Center ENT and Audiology
- 11) North Country Otolaryngology and Audiology
- 12) Dartmouth- Hitchcock Medical Center ENT and Audiology

Other (please write in below):

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Signature of Parent/Guardian: \_\_\_\_\_

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

Print Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_

Language used in the home: \_\_\_\_\_

Child's Name: \_\_\_\_\_

School District/School Name: \_\_\_\_\_

### **CARES Team mailing address:**

P.O. Box 201  
Poultney, VT 05764

### **CARES Team contact information:**

Pam Hoover, MS, TOD, Director  
(800) 770-6103 ext 225

Darren McIntyre, Assistant Director  
(800) 770-6103 ext 201