THE HAGEDORN LITTLE VILLAGE SCHOOL

Jack Joel Center for Special Children

CONSENT FOR THE USE OF REMOTE THERAPY

Child's Name: _____

DOB: _____

District: _____

Please check the services below that you are requesting to be provided remotely (Video Conferencing, phone conference, email correspondence)

Check only those services that have been approved by your CPSE/CSE and are identified on your child's IEP:

_____ Speech

_____ OT

_____ PT

_____ Counseling

_____ Parent Counseling/Training

Important reminder: OT/PT services cannot be provided until an updated prescription for services has been received from your child's doctor.

I, (Parent/Guardian's Full Name) _____, consent to have my child's therapies noted above delivered remotely at this time.

I understand that my child's services will be delivered in this format until HLVS resumes full in person center based programming. Should HLVS resume full in person center based programming, my child may continue to receive services in this format, while on full remote instruction, at my request.

By signing below, I acknowledge there may be inherent risks with regard to security and privacy of the video conference platform Zoom.

I understand that these services will be delivered using an audio and video simultaneously.

Parent Name: _____Date: _____

Parent Signature: _____