

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize and give my consent for Cowichan Valley School District (CVSD) staff, including Inclusive Learning (IL) professional staff, to read, review and discuss the documents I have provided for the following student:

Student Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

I understand that the IL professional staff may include District Occupational Therapists, School Psychologists, Special Education Teachers, Speech and Language Pathologists, Counsellors, and District Administrators. I also understand the purpose of reviewing these documents may be to support planning for student programming and may include determining eligibility for designation as per the Ministry of Education's special education categories.

This consent will expire in June of the current school year.

Signature

Date

**School teams, Parent/Guardians are to sign this form when sharing documents from outside agencies with our district. Please submit this signed authorization with district screening documents to be reviewed by Inclusive Education Support staff.*

Reviewed Sept 2022