Infant/Early Childhood Mental Health Consultation Program
Parent/Facility Agreement

Child: _____ Date of Birth: _____

Parent/Guardian: _____

Address: _____ Zip Code: _____

Phone: _____ E-mail address: _____

- I authorize the Early Childhood Mental Health Project to provide, perform or participate within the following services. These services are offered at no cost. I give my permission for the Infant Early Childhood Mental Health Consultant to:
  - Observe my child in his/her classroom setting and consult with the staff at the Early Learning Facility.
  - Provide consultation services to myself and my child's teachers within the Early Learning Facility.
  - Conduct a developmental screen, using a standardized tool, across all domains of my child's development.
- I understand that the Infant Early Childhood Mental Health Consultant may provide me with information about child-related issues and resources within my community that could be helpful.
- I agree to provide any necessary information about my child and understand that this information will be kept confidential.
- I agree that the IECMH Program may collect a variety of data about me and my child(ren) and store these data on a secure database. Only professional staff authorized by PA Key will have access to these data. All data will be kept confidential, and aggregated data may be used in evaluation or research reports to help improve the program.
- I understand that I will be invited to participate in team meetings and action plan development. This participation is voluntary, and any party may discontinue participation at any time, preferably by notifying the other party in writing.

Parent/Guardian Signature _____ Date _____

Early Learning Facility _____

Facility Address _____

Contact: _____ Phone: _____

E-mail address: _____

I authorize the Infant Early Childhood Mental Health Consultation Project to provide, perform or participate within the following services.

- I will facilitate the Infant Early Childhood Mental Health Consultant's classroom visits, observations, review documentation and contact with the child's parent guardian.
- I agree to participate in team meetings, assist with collecting documentation and facilitate the implementation of recommendations to the consultant.
- I agree to keep all information review, shared and received confidential.
- I acknowledge that PA Key staff are mandated reporters for child abuse and childcare licensing violations.

Facility director signature _____ Date _____

Return this form to: PAIECMH@pakeys.org or fax 717-213-3749

FOR ADMINISTRATIVE USE ONLY

I revoke authorization related to the Early Childhood Mental Health Project. I understand this means my child will not receive screening or referrals to community-based services facilitated by ECMHC, and that the teachers working with my child will not receive information related to how best to work with my child in the classroom setting.

Parent/Guardian Signature _____ Date _____