NIAGARA COUNTY HEALTH DEPARTMENT
EARLY INTERVENTION PROGRAM

CONSENT FOR EVALUATION

Child Name: ______________________________ DOB: ___________________

I authorize the evaluation of my child by:

____
(Name of Evaluation Agency)
to determine my child's eligibility for the Early Intervention Program.

____
Signature of Parent/Guardian/Surrogate Parent Date

____
Parent Name Phone Number

____
Completed by Service Coordinator:

Date Referred to EIP: _____________________________________
Date Referred to Evaluator: ________________________________
Person Contacted: ____
45 Day Limit: ____
Reason for Referral: ______________________________________

ISC Name: ____
ISC Phone: ____

The following is included if checked:
☐ Signed Physician Prescription