Demographics sticker OR

Name:
DOB:
Health No:

# CONSENT FOR PEDIATRIC SERVICES

In signing this consent, I understand and agree to the following:

- I consent to observation, assessment, treatment and monitoring provided by Pediatric Therapies
- The treating therapist(s) will explain their assessment findings and treatment recommendations including risks and consequences
- I have the right to ask questions about the treatment
- I have the right to decline or discontinue treatment at any time
- Information obtained during the course of assessment and treatment will be managed in accordance with the Health Information Privacy Act (HIPA - Section 23) and LAFOIP rules for collection, use, and disclosure of information *
- Services may be completed by a provisional licensee or an intern under the supervision of registered/licensed pediatric services personnel

For services provided by Northwest School Division, I consent to allow this service to be continued during my child's attendance in Northwest School Division unless discontinuation of services is initiated by the caregiver or therapist.

For services provided by Prairie North Health Region, this consent form is valid for a period of twelve (12) months maximum unless otherwise specified:_____.

I have read and understand this consent including possible risks & consequences:

| **Signature of Patient or Legal Representative:** | **Printed Name:** | **Relationship to Patient (if not self):** | **Date:** |
|---|---|---|---|
| X | | | |

| Witness to signature: | Printed Name: | Relationship to signer or professional title: | Date: |
|---|---|---|---|
| | | | |

**Office Use Only**

Created: May 2015 Revised: Sept. 2015 Revised: