Designate Consent Form

1. The “Check It Out” Drop-in program involves the following professionals (collectively called **“the Agencies”**) working together to ensure families can receive comprehensive support for child development issues:

CORE Team Members

Early Years Facilitator
EarlyON Child and Family Centres

Speech and Language Pathologist
- Early Words
(Affiliated Services for Children and Youth)
- Hamilton Health Sciences
(McMaster Children’s Hospital)

Public Health Nurse
Healthy & Safe Communities Department, City of Hamilton

Mental Health Resource Worker
Lynwood Charlton Centre

Early Childhood Resource Teacher
- Community Living Hamilton
- City of Hamilton

Child Care Subsidy Worker
Healthy & Safe Communities Department, City of Hamilton

ADDITIONAL PARTNERS

Infant Parent Therapists
Hamilton Health Sciences

Physiotherapist
Hamilton Health Sciences

Dental Hygienist
Healthy & Safe Communities Department, City of Hamilton

Occupational Therapist
Hamilton Health Sciences

Program Facilitator
EarlyON Child and Family Centres

Other
***you will be notified upon arrival of other community professionals in attendance**

2. In order to provide your child with the services available through the “Check It Out” Drop-in program, we need to collect, use and disclose personal information and/or personal health information about you and your child shared with us for the purposes of the Check It Out.

3. Information collected will be used for the following purposes:

(a) to help give you the best possible information about your child’s growth and development;
(b) as appropriate, to refer your child to agencies associated with the “Check It Out” Drop-in program for potential provision of support services;
(c) to administer and operate the “Check It Out” Drop-in program;
(d) to assist the City of Hamilton and the “Check It Out” Drop-in program with research, planning, reporting, evaluation and accountability purposes.

The collection, use and disclosure of personal information and/or personal health information will be limited to the minimum amount necessary to carry out these stated purposes.

4. Any personal information and/or personal health information collected will be kept confidential and will be used and disclosed only during the time in which your child is participating in the “Check It Out” Drop-in program, or upon the request of the custodial parent/legal guardian or as otherwise permitted or required by law.

CONSENT

I, _____, hereby consent to
Name of Custodial Parent/Legal Guardian (*please print*)

the "Check It Out" Drop-in program and each of the Agencies collecting, using and disclosing personal information and/or personal health information about me and my child, as identified below, to the extent that information is needed to carry out the purposes listed above in paragraph 3.

I also hereby consent to the exchange of personal information and/or personal health information about me and my child between the "Check It Out" Drop-in program and each of the Agencies to the extent that information is needed to carry out the purposes listed above in paragraph 3.
I understand that speaking with staff from the Agencies will not always result in a referral to other services.

I also hereby allow the designate identified below (if any) to attend the "Check It Out" Drop-in program in my place with my child, and to share personal information and/or personal health information about me and my child with the Agencies for the purposes listed above in paragraph 3.

Please print:

Parent's first name:	Parent's last name:
Designate's first name (if applicable):	Designate's last name (if applicable):
Child's first name:	Child's last name:
Child's birth date: (year / month / day)	Child's gender: ☐ male ☐ female
Address:	Postal Code:
Telephone:	Email:
What is the best way to contact me? ☐ Phone ☐ Mail ☐ Email	

I consent to the "Check It Out" Drop-in program sharing personal information and/or personal health information about my child with my child's doctor if health care services are recommended or required. ☐ Yes ☐ No If yes, please fill in the information below:

_____ _____ _____
Doctor's Name Doctor's Phone Number location

How did you find out about the "Check It Out" Drop-in program?

_____

We seek feedback from clients on a regular basis in order to improve services. May we please contact you in the future for this purpose? ☐ Yes ☐ No

I hereby state that I have read and understand the contents of this Consent form. I declare that this Consent has been given voluntarily. I understand that this Consent shall remain in force and effect until the end of my child's involvement in the "Check It Out" Drop-in program and its related services.

I understand that I may change or withdraw my consent at any time by giving the "Check It Out" Drop-in program notice in writing. However, I also understand that, if I change or withdraw my consent, it will limit the range of services available to assist my child.

_____ _____
Signature of Custodial Parent/Legal Guardian Relationship to Child

Date: _____ (year / month / day)

This information is collected under the legal authority of s. 5 of the *Health Protection and Promotion Act* and s. 227 of the *Municipal Act, 2001*. The information will be used for the purpose of administering the "Check It Out" Drop-in program, including for the purposes of determining eligibility for services, program evaluation and statistical use. For more information, contact [Rachelle Ihekwoaba/Project Manager] Early Years, Healthy & Safe Communities Department, City of Hamilton, at 905-546-2424 ext. 1092