Aspire Child Development Centre

School Services

Parent Application Form

Family Information

Child's Full Name

First: _____ Middle: _____

Last: _____

Birth Date (Month/Day/Year): _____

☐ Male ☐ Female ☐ Other _____

Alberta Health Care Number: _____

Child's Home Address:

Address: _____

City: _____ Province: _____ Postal Code: _____

Parent/Guardian (primary contact):

Name: _____

Relationship to Child:

☐ Mother ☐ Stepmother ☐ Foster Mother ☐ Adoptive Mother

☐ Father ☐ Stepfather ☐ Foster Father ☐ Adoptive Father

☐ Paternal Grandfather ☐ Maternal Grandfather

☐ Paternal Grandmother ☐ Maternal Grandmother

Contact Phone Number: _____

Address (if different form child): _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

Parent/Guardian (secondary contact):

Name: _____

Relationship to Child:

☐ Mother ☐ Stepmother ☐ Foster Mother ☐ Adoptive Mother

☐ Father ☐ Stepfather ☐ Foster Father ☐ Adoptive Father

☐ Paternal Grandfather ☐ Maternal Grandfather

☐ Paternal Grandmother ☐ Maternal Grandmother

Contact Phone Number: _____

Address (if different form child): _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

Others Living in the Child's Home

Name: _____

Relationship: _____ Age (if child): _____

Name: _____

Relationship: _____ Age (if child): _____

Name: _____

Relationship: _____ Age (if child): _____

Name: _____

Relationship: _____ Age (if child): _____

Parental Relationship and Custody Status:

It is important for us to know the status of the parental relationship in order to ensure we have consent for assessment from the custodial parent(s). Please state the status of your parental relationship below. Please provide a custody agreement if applicable.

☐ Single ☐ Married/Living Together

☐ Separated/Divorced ☐ Widowed

☐ Sole custody (please provide copy of custody agreement)

☐ Joint/Shared custody (please note that both parents will be required to consent to services if not living at the same address as the child)

☐ Retained custody (in the case of death or desertion of one parent)

☐ Alternating/Divided custody (please provide copy of custody agreement)

☐ Third party custody (please provide copy of custody agreement)

Community Services

Please take the time to complete in full.

Service/Professional	Name	Clinic/Address	Phone	Involvement
Family Doctor				☐ Past ☐ Current
Pediatrician				☐ Past ☐ Current
Psychologist				☐ Past ☐ Current
Occupational Therapist				☐ Past ☐ Current
Speech Language Pathologist				☐ Past ☐ Current
Physical Therapist				☐ Past ☐ Current
Audiologist				☐ Past ☐ Current
Neurologist				☐ Past ☐ Current
Psychiatrist				☐ Past ☐ Current
FSCD (Family Supports for Children with Disabilities)				☐ Past ☐ Current
Child Development Consultant/ Behaviour Specialist				☐ Past ☐ Current
Early Intervention Staff (AHS)				☐ Past ☐ Current
Other				☐ Past ☐ Current

Diagnostic Information

Has your child ever been given a formal diagnosis? ☐ Yes ☐ No

If yes, please share the diagnosis and if there is an additional diagnosis you are wondering about.

_____

If no, is there a diagnosis you are wondering about or that has been queried?

_____

Acknowledgement and Consent for Services:

☐ I consent for services to be carried out by Aspire Child Development Centre.

☐ I have received a copy of the application for services completed by my school.

Guardian - Please Sign Here

I hereby certify that the information provided on this form is true, correct and complete to the best of my knowledge and I will keep Aspire Child Development Centre advised of any changes.

_____

Parent/Guardian Name (Print Name) Parent/Guardian (Signature)

_____

Parent/Guardian Name (Print Name) Parent/Guardian (Signature)

_____

Date

Aspire Child Development Centre complies with all relevant privacy legislation. All information collected will be compiled for the exclusive use of Aspire Child Development Centre and will not be available for any other organization.

If you have any questions or concerns regarding privacy, you may contact Jordan MacDonald, Privacy Officer at: jmacdonald@aspirechild.ca or 403-340-2606.

CONSENT FOR ASSESSMENT AND THERAPHY SERVICES
(In-Person and Telehealth)

Child Information

First: _____ Middle: _____ Last: _____

Birth Date (Month/Day/Year): _____ / _____ / _____

☐ Male ☐ Female ☐ Other _____

I hereby consent to the provision of therapy services (i.e., assessment, observation, intervention strategies, consultation, targeted groups, and consultation with school, therapist, and community supports) by:

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech-Language Pathology
- ☐ Behaviour Specialist

I understand that therapy services may occur in person or by telehealth.

Telehealth

I understand that:

- Telehealth is the use of information or communication technologies to allow you to connect via technology to receive services when an in-person visit is not possible.
- Despite using a secure form of technology there is the potential risk of decreased confidentiality when using any form of telecommunications.
- Confidentiality still applies in telehealth sessions will not be recorded, unless agreed upon by all parties.
- All telehealth sessions will be conducted in Alberta, Canada
- Visual cues, and communication is more easily misunderstood and therefore there may be the need for clarification in person, if misunderstandings arise.
- Access to a computer, laptop, tablet or smart phone equipped with a webcam, microphone and speaker is required for session.
- It is important to be in a quiet, private space that is free of distractions during the session.
- It is important to use a secure internet connection, rather than public Wi-Fi during the session.
- If the connection is poor, you will be contacted to set up a time for the session to be resumed.
- It may be determined that in-person sessions are more appropriate and that those be resumed when possible.

Benefits and Risks of Evaluation

Benefits of Assessment Include:

- Insight into the nature of your child's strength and weaknesses
- Appropriate treatment recommendations
- Facilitate services in the community or at school.

Risks of Assessment Include:

- Children may experience discomfort (e.g., frustration, anxiety, etc.)
- The process and results of assessment can be emotionally difficult for parents/guardians.

While the assessment and treatment recommendations are based on best practices, you or others may not agree with the conclusions based on the results of assessment and the therapist's professional judgement. It is the parent/guardian's decision whether to follow the recommendations, utilize the provided strategies or whether to obtain further evaluation.

Electronic Communication of Information

I understand that information may be communicated by email and/or text message. Therapists will take appropriate measures to maintain security and confidentiality for both sent and received text and email information.

Confidentiality

This program utilizes a multidisciplinary team. Therapists overseeing my child share information and collaborate to provide services. Administrative staff will have access to the pieces of information that are required for them to complete their tasks.

If your child participates in another Aspire program, the staff of that program will also have access to the information.

Consent

I understand why I have been asked to consent to therapy services for the forenamed child and I am aware of the risks or benefits of consenting or refusing to consent. I agree to in person and telehealth services, and that information may be sent electronically. I may revoke this consent at any time by submitting a written revocation document. I understand that a photocopy or facsimile of this consent shall be as valid as the original.

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Last updated: November 6, 2024
To be reviewed: November 6, 2025

CONSENT FOR PSYCHOLOGICAL CONSULTATION AND THERAPHY SERVICES
(In-Person and Telehealth)

Child Information

First: _____ Middle: _____ Last: _____

Birth Date (Month/Day/Year): _____ / _____ / _____

☐ Male ☐ Female ☐ Other _____

Types of Psychology Services

I understand that my child may receive the following psychology services:

- Consultation Services: The Psychologist will work with you to provide information and assistance with supporting a child's developmental, behavioural and emotional needs. The psychologist will recommend strategies that are based on your child's developmental abilities; family and/or school identified needs; the resources available; as well- established practices.
- Therapy Services: Psychological Therapy services address concerns directly with your child. Therapists will provide direct intervention to your child on a regular basis. Therapeutic treatment is more intensive than consultation. Treatment plans are based on your child's developmental abilities, family-identified needs, and the resources in the home or community setting, as well as established practice.
- Telehealth: Telehealth is the use of information or communication technologies to allow you to connect via technology to receive services when an in-person visit is not possible.

Psychologist Responsibilities

I understand that it is the psychologist's responsibility to fully explain the consultative process, as well as provide information and strategies that is in keeping with best practices. The Psychologist is responsible for writing goals as well as reporting on goal progress in the event that services are being provided as a home-based contract. The psychologist will refer to another psychologist if it is deemed in the family's best interest.

I understand that for telepsychology services the psychologist will choose a platform that meets the standards of the College of Alberta Psychologists. Despite this there is a risk to confidentiality, and this is true for texts and emails as well.

- Visual cues, and communication is more easily misunderstood and therefore there may be the need for clarification in person if misunderstandings arise.
- I will need a webcam or a smart phone for video sessions
- It is important to use a secure internet connection rather than public Wi-Fi.
- It is important to be in a quiet, private space that is free of distractions for video and phone sessions
- If the connection is poor, the psychologist will contact you to set up a time for the session to be resumed.

I understand that the psychologist will review the information on this form with me.

Benefits and Risks

I understand that the benefits of obtaining consultative services from a psychologist include (but are not limited to) gaining a greater understanding of my child's behavioural, mental and emotional functioning, the development of strategies, and referral to additional resources.

I understand that the risk in obtaining consultative services from a psychologist to include receiving general strategies based on information provided by the family when the psychologist is not able to directly observe or trail strategies with your child.

Parents Responsibilities

I understand that it is my responsibility to share all relevant information with the psychologist so that she/he is able to suggest the most appropriate strategies to help me and my child.

I understand it is my responsibility to disclose all relevant information to the psychologist in order to help develop strategies. It is my responsibility to follow through with suggestions or communicating why the given strategies were not effective. In understand that the consequence on non-action may mean that their child's progress is hindered.

Confidentiality & Limits of Confidentiality

All communications with the psychologist and all records relating to psychological services are confidential and cannot be disclosed without written consent from the parent or guardian. There are situations in which the psychologist is legally and ethically obligated to limit the confidential nature of the psychological services provided.

These situations include:

- If I am hurting my child or have knowledge that someone else is hurting my child.
- If I am at risk to harm myself.
- If I have knowledge that someone else is being harmed or may be harmed.
- If a court orders the disclosure of records.

In addition:

- When referred by a third-party payer (e.g., school), the referring party will receive a copy of the final report.
- This program utilizes a transdisciplinary team. Therapists overseeing my child share information and collaborate to provide services. Administrative staff will have access to the pieces of information that are required for them to complete their tasks.
- If your child participates in another Aspire program, the staff of that program will also have access to the information.

Please note that the psychologist cannot guarantee confidentiality when electronic communication (i.e. email, text, Telehealth) is in use between parent/guardian and the psychologist. Information kept on a database may be subject to privacy breach.

Electronic Communication and Information Storage

I understand that information may be communicated by email and/or text message. The psychologist will take appropriate measures to maintain security and confidentiality for both sent and received text and email information.

I understand that both paper and electronic files are stored in accordance with standards as outlined by the College of Alberta Psychologists. Information collected may be accessed by administrative staff for the purpose of editing, printing, and mail outs. Parents are given copies of all session notes and program plans if completed.

Additional Information

I understand that services at Aspire Special Needs Resource Centre are often transdisciplinary, therefore information shared with the psychologist may be shared with a member of your child's team in order to provide the most comprehensive service.

I understand that I can contact the College of Alberta Psychologists if I have any concerns or complaints.

I understand that if I wish to rescind this consent, I can do so at any time in writing.

Consent

I understand why I have been asked to consent to psychology services for the forenamed child and I am aware of the risks or benefits of consenting or refusing to consent. I agree to in person and telehealth services, and that information may be sent electronically. I may revoke this consent at any time by submitting a written revocation document. I understand that a photocopy or facsimile of this consent shall be as valid as the original. I hereby give my consent for my child to receive the above mentioned psychological services.

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

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