

## FOLLOW ALONG PROGRAM PERMISSION FOR ENROLLMENT

The Follow Along Program has been explained to me orally. I have received a brochure explaining the program and information about how to contact the local agency. With the following conditions,

I agree to enroll \_\_\_\_\_, \_\_\_\_\_, in the Follow Along Program.

(Child's Name: First, Middle, Last)

(Date of Birth)

### **MY RESPONSIBILITIES**

I will take part in a home, office, clinic, or telephone visit by a nurse or developmental specialist who will share information with me about the Follow Along Program, family health, and services available in my community.

I will complete questionnaires that ask about my child's growth and development when my child is 4, 8, 12, 16, 20, 24, 30, 36, 42 and 48 months of age. I will return the completed questionnaire (which has been pre-stamped with appropriate postage) to Benton County Human Services - Public Health Unit. (I understand that I may be asked to complete some of the questionnaires after my child reaches a certain age if he/she was born prematurely.)

### **MY RIGHTS**

I will be informed of my child's questionnaire results after a questionnaire is scored. If the questionnaire results are not within the normal range, a professional will contact me to discuss the next steps..

I can withdraw my child from this program at any time by telling Benton County Human Services - Public Health Unit that I don't want to continue with the Follow Along Program.

I will have access to all information obtained about my family through participation in the Follow Along Program..

### **MY CONSENT FOR DISCLOSURE OF CONFIDENTIAL AND PRIVATE INFORMATION**

The purpose and intended use of the information is:

- to support parent's efforts to keep their child as healthy as possible;
- to provide parents with information regarding their child's health and development on a regular basis;
- to make it easier for families to get help if it is wanted and needed;
- to collect information in order to find out how we can better serve children and the families of children who may have special needs.

Medical and personal information about my child and family, and information from the developmental questionnaires, may be shared between 1) Dr. \_\_\_\_\_ (name of child's physician) to keep the doctor advised of my child's development, 2) Benton County Human Services, and 3) early intervention services in the education district through IEIC (Inter-Agency Early Intervention Committee) in order to address health and developmental concerns identified through the Follow Along Program.

If we move to a county with a Follow Along Program or similar tracking program, I agree that information may be sent to our new county without additional permission.

Information from the Follow Along Program, which does not include identifiable information such as names, addresses, or phone numbers, may be compiled regionally or statewide to help with the planning of early intervention services and the evaluation of the program.

Except as noted above, private information about my child or family will not be shared with any person or agency without my written permission.

My consent for disclosure of private information will be valid through my child's 4th birthday. I have reviewed the above information and understand its content. I have received a copy of the Client's Bill of Rights.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Nurse Signature)

\_\_\_\_\_  
(Date)

Phone Number  
School District  
# in household  
Yearly Income

