



**Parent/Legal Guardian
Consent to Screen, Obtain, and
Release Information**

Metro United Way

Your Participation in the Ages & Stages Questionnaires® (ASQ) Means:

- Ages & Stages Questionnaires® (ASQ™) screenings will be completed on your child's overall developmental skills. These screens will identify your child's strengths as well as any areas where your child may need practice or support.

Giving Permission Means:

- You agree to participate in the ASQ™ developmental screenings.
- Metro United Way's Developmental Screening Hub will contact you for future screenings. You can opt out of these future screenings at any time.
- Your child's ASQ™ results will not be released to other persons, programs, or schools without your permission.
- You always have access to all information collected by Metro United Way's Developmental Screening Hub about your child.
- You agree to ongoing communication and screenings through Metro United Way's Developmental Screening Hub.

How ASQ Information Is Shared:

Your child's ASQ™ results through Metro United Way's Developmental Screening Hub are shared only with you and the provider(s) you indicate below. By selecting an agency, you are agreeing to allow Metro United Way to provide information on your child's ASQ results and referrals to the agency listed below.

I, _____, legal guardian of _____, give my permission to **obtain and release** necessary information to/from other agencies/individuals listed below to assist in receiving appropriate services for _____, birthdate _____/_____/._____.

CHECK ALL THAT APPLY

Obtain Release

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Metro United Way's Developmental Screening Hub	_____
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Play Cousins Collective:	_____
<input type="checkbox"/>	<input type="checkbox"/>	First Steps:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child Care Provider:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Local Head Start:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Local School District:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Health Care Provider: Healthcare practice name: (ex. ABC Pediatrics):	_____
		Healthcare provider's name: (ex. Dr. Smith):	_____
		Address:	_____
		Phone Number:	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other:	_____
		Phone Number:	_____
		Name of provider(s) and/or individual(s) (ex. Grandparent, Aunt etc.)	

Sign Here

Parent/Guardian Signature

Date

Print Parent/Guardian Name

Phone

This consent is valid until child reaches age six or until notified by parent/guardian.

Metro United Way, 334 East Broadway, Louisville, KY 40202

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