SUFFOLK COUNTY PRESCHOOL

CONSENT FOR THE USE OF TELEPRACTICE DURING DECLARED STATE OF EMERGENCY FOR COVID-19
AUDIO and VIDEO

Student's Name:	School District:	DOB: / /
Address:		Apt #:
City/Town:	State: New York	Zip Code:
Service Type to Be Delivered Using Telepractice:	Service Mandate:	
Name of Therapist/Teacher:	Phone #:	
Little Angels Center	Email:	

Instructions: This consent form for the use of Telepractice as a service delivery method for the provision of CPSE services must be completed for each service type authorized for the above referenced student before telepractice services can be initiated. Telepractice as a preschool related service / SEIS delivery method is only available *during the declared state of emergency* for COVID-19.

A consent form for the use of Telepractice can be returned by email if the parent/guardian also signs and returns the Suffolk County Parental Approval to Use E-mail to Exchange Personally Identifiable Information.
The consent form for the use of Telepractice must be signed and returned prior to the initiation of services. A separate consent form is required for each service.

I, (Parent/Guardian's Full Name) , consent to have my child's

(enter service type)_____service delivered using Telepractice as a service delivery method for Related Services/SEIS services listed on his/her IEP. I understand that the Telepractice services that my child will be receiving will fulfill the service mandate in my child's Individualized Education Plan (IEP) and are not being delivered in addition to the services that my child is authorized to receive.

I understand that Telepractice a preschool related service/SEIS service delivery method is only available during the declared state of emergency for COVID-19 and that my child's services will be delivered using the method authorized in my child's IEP after the declared state of emergency.

I understand that Telepractice means that the CPSE services will be delivered using **an audio and video at the same time** for the duration of the session.

My child's therapist/teacher has explained how the service will be delivered and I further understand my role in assisting with the service delivery.

I understand that I will have access to all information resulting from the sessions conducted via Telepractice in the same way I would when services are delivered as per the mandated IEP.

☐ By checking this box, parent confirms:
provider called to obtain verbal consent on____ ____ ____ for immediate initiation of telepractice services parent will sign and email the form back to provider within 48 hours of receipt via email or US mail

_____
Parent Name (Print)

_____ _____
Parent Signature Date