Rozanne Israel, B.Sc. (Log)
Speech-Language Pathologist, Reg. CASLPO

## CONSENT TO TREATMENT

I, (Parent's full name) ______________________________________________ give consent for

my child (Child's full name) ___________________________________________ to receive speech

and/or language intervention and/or assessment from Rozanne Israel, Speech Language Pathologist or her associates.

I further acknowledge that Ms. Israel or her associates have explained the nature of treatment I can expect and I give consent for them to use the PROMPT system if appropriate in their work with my child. I understand that the PROMPT involves touching my child's face and providing neck/back support as needed. I am aware of the inherent health risks and am comfortable with the precautions Ms. Israel or her associates have outlined (E.g. hand washing; hand sanitizing; cancellation of sessions when ill to reduce transmission)

I have read Ms. Israel's Privacy Policy and the "Welcome Letter" which outlines clinic policies, including payment schedule; fees and cancellation. I have had the opportunity to interview the clinician and ask her questions about her work experience and scope of practice. She has made no guarantees regarding my child's prognosis but has provided insight into the types of interactions I can expect to observe in her sessions.

In giving my informed consent for her to work with my child, I understand that I have the right to withdraw this consent at any time with immediate effect. I acknowledge that Ms. Israel encourages open dialogue between herself and her clients and I may feel free to discuss any concerns I have regarding her treatment of my child. I am encouraged to watch and/or participate in all of my child's sessions.

| ______________________________ | ________________________ |
|---|---|
| (signature) | (witness) |
| ______________________________ | ________________________ |
| (Relationship to Child) | (date) |