



## Family and Early Childhood West

1-855 (4KidsNB) 454-3762

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### Consent to Release and Receive Information

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_  M  F

Date of Birth: \_\_\_\_\_  
(Day) (Month) (Year)

Address: \_\_\_\_\_  
(Please use mailing address and include postal code)

Telephone: (Home) \_\_\_\_\_ (Other) \_\_\_\_\_ Email: \_\_\_\_\_

Mother/Legal Guardian: \_\_\_\_\_

Father/Legal Guardian: \_\_\_\_\_

**The EYE-DA is administered in English.**

**Please contact us prior to the assessment at 1-855-454-3762, if your child is unable to complete the assessment in English. Please indicate your child's first language.**

French  Other (indicate) \_\_\_\_\_

By signing this form, I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_, give **Family and Early Childhood West** permission to assess my child using the pre-kindergarten assessment tool, the **EYE-DA**, contact me with the results and release the results to the school my child will be attending and to the Department of Education and Early Childhood.

Name of School: \_\_\_\_\_

Signatures:

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Parents or Legal Guardians