



Observation Consent Form

Current School / Program Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Student Information

Name _____

Last

First

Middle

Address _____

City _____ State _____ Zip Code _____

Phone _____

I, the undersigned, hereby authorize Keystone Center for Children with Autism, Inc. staff to observe the above named child in his/her classroom/program. I further grant permission for the school/program personnel to discuss with and provide the staff of Keystone Center for Children with Autism, Inc. with all relevant information and records pertaining to my child's academic and behavioral performance, including assessment findings and recommendations.

This authorization is valid only for the facility to which this form has been addressed and will expire only if revoked by myself. I understand that I may revoke this authorization, in writing, at any time. A photocopy of this signed form is acceptable and may be honored as the original.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date