



Family and Early Childhood West

1-855 (4KidsNB) 454-3762

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:

Parents or Legal Guardians