

# THE OHIO CENTER FOR



# DEAFBLIND EDUCATION

## Deafblind Technical Assistance Program (DBTAP) Parent Release to Share Information

Child's Name: \_\_\_\_\_

Parent/ Legal Guardian's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

County Of Residence: \_\_\_\_\_

I give permission for the Ohio Center for Deafblind Education to exchange information about my child with the following entities for use in the Technical Assistance On-Site Consultation as provided through the Deafblind Technical Assistance Program (DBTAP). I also give permission for my child to be observed in the school, when applicable. (Please check all that apply.)

\_\_\_\_\_ Early Intervention Program

\_\_\_\_\_ School District \_\_\_\_\_  
(Please Specify School District)

\_\_\_\_\_ Community Agency \_\_\_\_\_  
(Please List All Agencies)

\_\_\_\_\_ (Optional) By initialing here, I also agree to give consent for The Ohio Center for Deafblind Education to provide Helen Keller National Center with information regarding my child.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please return original form with signature to:**

The Ohio Center for Deafblind Education

Attn: Outreach Specialist

936 Eastwind Drive

Westerville, Ohio 43081