



Statement of School Services Waiver of Medical Liability

Parent Contact Information:

Name: _____

Home Address: _____

Phone (home): _____ Phone (cell): _____

E-mail Address: _____

School Contact Information:

School Representative's Name: _____

School Address: _____

Phone: _____

E-mail Address: _____

Professional school consultant performing the School Observation & Training for Selective Mutism:
Jennifer Brittingham, M.A.

By signing below, you understand and agree to the following:

School based assessment procedures and consultation services are **for educational purposes** to develop and monitor the school accommodation and intervention plan. **Information presented during the School Observation & Training for Selective Mutism is based solely on** the information provided by parents and school professionals, as well as, direct observation/assessment by the SMart Center School Consultant.

School based services are **not meant to replace an initial in-person evaluation of your child. At no time is a medical or psychological diagnosis made or confirmed** nor are recommendations supplied for outside of the school environment. Should a diagnosis be required a referral may be made to a qualified treating professional.

The school consultant will use the SM-CDQ-Brief© and the SM School Evaluation form© as well as observe the child with symptoms of SM and/or consult with school staff. Recommendations for accommodations/interventions within the school will be made. A brief report will be supplied summarizing findings and recommendations.

Parent Signature: _____ Today's Date: _____

School Representative Signature: _____ Today's Date: _____