

Illinois Birth to Three Institute

Parents Too Soon Pregnant & Parenting Program

Ounce of Prevention Fund
Illinois Department of Human Services
Chicago Public Schools
Illinois State Board of Education
Governor's Office of Early Childhood

Participant Name: _____ **ID#** _____

Agency Name:

I understand that my participation in the program is voluntary and may include meetings with home visitors, attendance of parent groups, developmental screenings, mood screenings, and parenting questionnaires.

To make sure that the above agency can better serve, coordinate, and evaluate their work with me, I give permission for them to share the following information from my records only with the Ounce of Prevention Fund/Illinois Department of Human Services/Chicago Public Schools/Illinois State Board of Education/Governor's Office of Early Childhood: 1) intake information, including my name; 2) service use information; 3) history of life events; 4) responses to all screenings and questionnaires (including developmental screenings, mood screenings, and parenting questionnaires).

All information I am providing will be held strictly confidential to protect the privacy of my family and me. I understand that my information may also be used together with information from all participants to 1) evaluate the program, 2) plan for the program, and 3) promote the program. All information used will only be presented in the form of summary reports to Ounce departments, funders, or legislative (political) audiences. None of these reports will ever identify me as an individual or provide any of my individual information.

I have been informed that my information will be stored in locked files, in password protected computer files, or in secured, password-protected, electronic files in the OunceNet online information management system. Only the Ounce of Prevention Fund/Illinois Department of Human Services/ Chicago Public Schools/Illinois State Board of Education/Governor's Office of Early Childhood can access any of my information through reports available to them. I understand that I may ask at any time what information is held and in what way it is held, and I have the right to object to these. I understand that I have the right to inspect and copy the information held, that no information may be released to any other person or organization without my written consent, and that I may withdraw this authorization in writing at any time. I give my consent and request to be a participant at the above agency.

Ounce of Prevention Fund is committed to preserving individual privacy rights on the Internet. Ounce of Prevention Fund will only hold your personal information for as long as is necessary for the purposes for which it is collected. The Ounce of Prevention Fund uses industry-leading technology to keep your personal information as secure as possible. Please let us know if you have any questions.

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Consent to Participate

Participant Name: _____ **ID#** _____

Agency Name: _____

Date: ____ / ____ / ____
(mo./day/yr.)

Signed: _____
Participant

Please supply the name & address of two people who will know where to contact you.

Contact Person _____
Address _____
City _____
State _____ Zip Code _____
E-mail _____
Phone # _____

Contact Person _____
Address _____
City _____
State _____ Zip Code _____
E-mail _____
Phone # _____

Signature of Parent/Guardian if Participant is a Minor
(Optional According to Agency practices, not required for evaluation)

Witness (Name & Position of Staff Person)