

**Nassau County Department of Health  
Preschool Special Education Program**

**PARENT/GUARDIAN CONSENT FOR ALTERNATE VERIFICATION SIGNATURE**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_ give  
(Parent/Guardian's Name Printed)

permission for the following individuals to sign treatment logs on my behalf.

Please list individuals who will be able to sign - Day Care Staff, Teacher, Caregiver, etc. (must be over 18)

First Name/Last Name	Title	Signature	Email

\_\_\_\_\_  
(Parent/ Guardian Signature)

\_\_\_\_\_  
(Date of Signature)

I, \_\_\_\_\_ hereby withdraw the above permission as of \_\_\_\_\_.  
(Print name of Parent/Guardian) (Date of Withdrawal)

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)