Suffolk 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 and Last Name	Title	Email Address	Signature

_____ _____
(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)