

**Christina Watson, Psy.D.
Clinical Psychologist, PSY 19976
16870 West Bernardo Dr., Ste 400
San Diego, CA 92127
858-342-4262**

CHILD INFORMED CONSENT FORM

I, the undersigned parent(s)/legal guardian(s) of _____, give my consent for Dr. Watson to conduct a psychoeducational evaluation with my minor child to include intellectual, academic, and other processing assessments as needed to address presenting concerns. I understand that results including but not limited to definitive diagnosis are not guaranteed, and that a diagnosis does not guarantee that my child will qualify for services at his or her school under the educational code, or for accommodations by any other entity.

I also understand that information regarding my child and our family is confidential and will not be shared without my consent. I acknowledge that there are exceptions to this, including suspected child abuse, child pornography, elder abuse, and intent to harm self or others. In these specific cases, I understand that confidentiality does not apply and Dr. Watson is a mandated reporter under the law.

I agree to allow recording of my child's verbal responses during test administration to facilitate accurate scoring, with the understanding that the recordings are automatically erased upon finalizing the scores.

Printed name of parent/legal guardian 1

Signature of parent/legal guardian 1

Printed name of parent/legal guardian 2

Signature of parent/legal guardian 2

Date signed