RurAL CAP Head Start/Early Head Start

Consent for Screenings and Programs Services

Child's Name: _____ DOB: _____ Community: _____

For First Aid and Health Screenings:	**circle one**
Health Screenings: I authorize Head Start staff and/or a trained medical staff to conduct growth measurements, hearing and vision screenings, and a trained medical staff to conduct a Physical/ Well Child Check that can include blood pressure, hemoglobin, lead screening, dental screenings/exams, varnish and fluoride, of my child for the purpose of assessing my child's health status.	Yes No
Basic First Aid: I authorize Head Start staff to administer basic first aid to my child during program hours.	Yes No
For Release of Contact Information:	
I authorize for my phone number and email address to be released to the local Parent Committee for Early/ Head Start activities.	Yes No
For Pictures/ Videos/ Social Media:	
Pictures: I authorize that pictures of my child taken during Head Start activities may be used in marketing materials including, but not limited to, newspapers, displays, brochures, social media, advertisements, promotional videos, partner/funder publications, etc., for educational and/or publicity purposes.	Yes No
Training Videos: I authorize Head Start staff to video my child in their classroom for training purposes with early childhood professionals outside of RurAL CAP Head Start.	Yes No
For School District Observations:	
General Observations: I authorize my child to participate in classroom observations in a group setting from a local/ regional school district. If individual observations are suggested, a parental authorization will be requested.	Yes No
Head Start Requirements: Educational/Developmental Screenings, Mental Health Observations, Medical Records	
Individual Observations: I understand that HS/EHS staff will conduct individualized observations for developmental assessments on my child.	Yes
Developmental Screenings: I understand that HS/EHS staff will conduct developmental screenings on my child to assess his/her stages of development.	Yes
General observations: I understand that my child will participate in classroom observations in a group setting from a local or distance contracted mental health consultant. If further observations are suggested, a parental authorization will be requested.	Yes
I agree to provide a copy of my child's current Physical Exam/ Well Child Check (which should include blood pressure, blood lead screening, TB screening and hemoglobin results) and Dental Exams, within 90 days of enrollment.	Yes

For CACFP Enrollment (days and hours may vary by site):

Hours attending	Days	Meals (Circle all that apply)
to	M T W TH F	Breakfast AM Snack Lunch PM Snack Supper

Infant Formula Selection: (EHS) *Complete if any child listed above is an infant under one year of age.*

Check one: ☐ I **accept** the center provided Similac iron fortified infant formula.
☐ I **decline** the center provided formula. *

*I understand that by declining the center provided formula, I agree to provide breastmilk or an approved iron fortified formula.

Parent/Guardian Signature: _____ Date: _____

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