Steve M. Tietjen, Ed.D. | County Superintendent of Schools

1840 WARDROBE AVENUE, MERCED, CA 95341 | (209) 381-5170 | WWW.MCOE.ORG

MEDICAL VERIFICATION OF RESPITE FORM
(To be completed by Medical Professional)

Child's Name:______________________ **DOB:**__________________

Child's Name:______________________ **DOB:**__________________

Parent's/Guardian's Name:_______________________ **Phone #:**________________

Address:____

This family may be eligible for Head Start/Early Head Start Full Day Services. The parent/guardian listed above has indicated that there are medical reasons that they are unable to care for the child for extended periods of time and therefore require some respite services.

The family is applying for Head Start Services. Head Start services low income families in Merced County. We ask that any fees associated with this form be waived.
Thank you for your consideration.
Head Start Staff

Please indicate the parent's condition and impact on their ability to care for their infant or preschool age child:

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This condition will be resolved:

- ☐ **Indefinite (no known end date at this time)**
- ☐ **Date of anticipated resolution**______________________________

Date this form was completed: ____

Doctor's Name: ____

Address: ____

Telephone Number: ____

Signature and/or Stamp of Medical Practitioner: ________________________________

STAFF USE ONLY

Child's Name: ______________________ Child's Name: ______________________

DOB: ____________________ DOB: ____________________

Date Received ______________________