OLHSA
A Community Action Agency

EARLY HEAD START / HEAD START
AUTHORIZATION FOR RELEASE OF MEDICAL & DENTAL INFORMATION

Name of Child:_____ DOB:_____

Address:_____ Phone: _____

_____

I give my consent for OLHSA Head Start staff to exchange and obtain information regarding Prenatal Records, Well-Child Checks/Physical Exams, Developmental Information, Immunizations, Lead and Hemoglobin Screenings, TB tests, Dental Exams and any chronic health conditions affecting participation in the program. Licensed medical professionals may release information regarding most recent medical/dental examinations and follow-up treatments.

If releases have been signed by the parent/guardian, the information may also be disclosed to Head Start partners to plan services for this child/family.

- **I understand** that I may inspect or copy the information used or disclosed.
- **I understand** that I may revoke this authorization at any time by notifying OLHSA Head Start in writing.
- **I understand** that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for services or enrollment in Head Start.

I understand that this signed release form will be considered valid for one program year in the Head Start program. I also understand that I may review this release, discuss it with program staff, or choose to remove it at any time during my child's enrollment in the Head Start program.

Signature _____ **Relationship**_____ **Date**_____

Witness _____ **Date**_____

Year 1 2 3

OLHSA

A Community Action Agency

EARLY HEAD START / HEAD START
PARENTAL CONSENT FOR HEALTH SERVICES/EMERGENCY TRANSPORTATION

I give permission for my child, _____ , to receive all required Head Start health screenings and examinations conducted by appropriate Head Start staff, Oakland County Health Division representatives, and/or licensed medical and dental providers participating in on-site screenings. These may include vision and hearing screenings, developmental screenings, behavioral screenings, speech and language assessments, height/weight measurements, blood pressure readings, non-invasive hemoglobin screenings, physical assessments and dental screenings. I understand OLHSA Head Start is not in any way responsible for the quality and accuracy of such screenings. I understand that these screenings are required to meet Head Start requirements.

I give permission for myself/family/child to receive services from the Mental Health Coordinator. I agree to allow the Mental Health Coordinator to counsel my family.

I give permission for my child to receive services from the Disabilities Coordinator. I agree to allow the Disability Coordinator to complete observations and assess for Disability needs.

I understand that this is not a substitute for a medical or dental home which provides ongoing care for my child's health needs.

I agree that my child will be examined during school hours and be accompanied by Head Start staff. I do not need to be present, but am always welcomed to accompany my child. I will be given a copy of the health screening form and the results will be shared with me.

I am aware that a current physical exam for child's age must be on file within the first 30 days of attendance in our program. The child's immunizations must be up to date for his/her age or a waiver must be in place on the first date of attendance.
I understand that my child may be placed on a waiting list until such time as these requirements are met.
I understand that no emergency treatment may be given without parental consent except in a life threatening situation. Because informed consent must be given at the time of the incident, I agree to leave numbers where I (or my spouse or a responsible adult designated by me) can be reached. This information may be found on my child's Child Information Record (emergency card).

- The program will provide first aid and take appropriate measures including contacting the emergency medical services (EMS) system.
- The program will arrange for emergency transportation to the nearest emergency medical facility, if necessary. At no time will a staff member drive with my child. My child will be transported by ambulance or other such vehicle when necessary. An OLHSA employee will accompany my child in the ambulance.

I understand that this signed consent form will be considered valid for one program year in the Head Start program.
I also understand that I may review this consent, discuss it with program staff, or choose to remove it at any time during my child's enrollment in the Head Start program.

Signature _____ **Relationship**_____ **Date**_____

Witness _____ **Date**_____

PARENT/GUARDIAN REFUSAL

I **do not** give permission for my child, _____ , to receive the required Head Start health screenings and examinations conducted by appropriate Head Start staff, Oakland County Health Division representatives, and/or licensed medical and dental providers participating in on-site screenings. I am aware that a current physical exam must be on file within the first 30 days of attendance and my child's immunizations must be up-to-date for age on the first date of attendance. I understand that my child may be placed on a waiting list until such time as these requirements are met.

Signature _____ **Relationship**_____ **Date**_____

Witness _____ **Date**_____