South San Antonio ISD
Head Start Program

Parent Consent for Release of Medical / Dental Records

Child's Name: _____ DOB: _____

Campus:_____ CPID # _____

Document	✔Item Needed
Physical Exam	
Medical Treatment Reports	
Lead Results Report	
Dental Exam	
Dental Treatment Reports	
TB Questionnaire / Skin Test Results	
Other:	

I, as the legal parent/guardian of the child named above, request the release of medical or dental documents from:

Doctor Name: _____ Dentist Name: _____

Address: _____ Address: _____

Office: _____ Office:_____

Fax:_____ Fax:_____

These documents are to be provided to SSAISD, Head Start Program, which my child is enrolled in. By granting my permission, I understand that the information will be used for the benefit of my child and will remain confidential.

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date

I have fully explained the purpose of this release to the parent/guardian noted above.

_____ _____

Signature of Head Start Staff Date