



# HEALTH CONSENT AND ACKNOWLEDGEMENT FORM



Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Your child may be eligible to receive hearing, vision, blood pressure, growth measurements, and developmental screenings through Head Start and/or collaborative partners. There is no cost for these services and you will be notified of the results. Some of these screenings will be done by trained staff at your child's site.

AGE	SCREENINGS: Please indicate whether you would like your child to receive the following by initialing the boxes in the "Initials" column to the right.	INITIALS
0-3 yrs.	<b>(Early Head Start Only)</b> I am aware that my child is required to have a complete well baby check-up/physical exam to include an oral visual exam as required by California State Guidelines for regularly scheduled visits. A complete <b>dental examination is required at 12 months.</b>	
0-5 yrs.	I have received information on the Health Handbook resource.	
0-5 yrs.	I grant permission for my child to have <b>ONGOING DEVELOPMENTAL ASSESSMENTS, ASQ-3 DEVELOPMENTAL SCREENING as well as an ASQ-SE MENTAL HEALTH SCREENING.</b> These screenings/assessments evaluate your child's development in speech and communication, fine motor skills, gross motor skills, social and emotional skills, and problem-solving skills. These screenings will help site staff provide support for your child.	
0-5 yrs.	I grant permission for staff to provide <b>social, emotional and behavioral consultation services</b> for my child as needed. These services support teachers and families to promote a child's social and emotional well-being.	
1-5 yrs.	I grant permission for my child to participate in the fluoride program ( <b>daily brushing with fluoride toothpaste</b> ). Regular tooth brushing helps to prevent cavities and gum disease.	
0 m-5 yrs.	I grant staff permission to perform the following health screening on my child: <b>HEIGHT AND WEIGHT.</b>	
3-5 yrs.	I grant permission for my child to have a <b>VISION</b> screening. Vision screenings will be conducted by Head Start and/or collaborative partners. If your child needs glasses, glasses will be provided to your child free of charge.	
0-5 yrs.	I grant permission for my child to have a <b>HEARING</b> screening. Hearing screenings will be provided by Head Start and/or collaborative partners.	
3-5 yrs.	I grant staff permission to perform the following health screening on my child: <b>BLOOD PRESSURE.</b>	
3-5 yrs.	I am aware that my child is required to have a complete <b>PHYSICAL and DENTAL EXAMINATION</b> annually. I will be responsible to ensure that all treatment and follow-up is completed.	

### Comments:

\_\_\_\_\_  
\_\_\_\_\_

I have read and understand the above information.

Date: \_\_\_\_\_

Parent Name (print) \_\_\_\_\_

Parent Signature \_\_\_\_\_