Head Start

"Building partnerships, changing lives"

Head Start Consents

Child's Name: _____ D.O.B. _____

Address: _____ Campus: _____

Transportation:

____ I authorize Head Start staff and bus drivers to administer basic first aid to my child in the classroom or while in transit, should injury occur.
____ I give permission for my child to be transported by Head Start for any parent authorized health services with advance notification.

Health/ Emergency Dental/One-on-One provision:

____ I understand that Head Start requires that all children participating in the program will receive certain screenings within forty-five (45) days of entry and additional screenings as necessary. At a minimum, the following screenings will be provided:

• Developmental • Hearing • Vision • Height • Weight • Social/Emotional • Speech

____ I give consent for my child to receive emergency dental treatment by a licensed dentist while under the care of Community Services of Northeast Texas, Inc. Head Start. This does not include consent to perform additional non-emergency surgical procedures. Additional consent is required for such procedures.
____ I acknowledge that certain services provided are individual in nature. Services for Professional Speech Therapy or Professional Behavioral Counseling from licensed individuals are provided through working partnerships with Head Start. I understand that during the provision of these services my child will be seen privately in a one-on-one setting. Each provider who interacts with my child on a regular basis has been subjected to the same background and fingerprint screening requirements as regular Head Start staff.

Photographs:

____ I give permission for my child to be photographed, including but not limited to: newspaper, TV, websites (including Facebook), campus newsletters, campus activities, and display boards.
____ I DO NOT give permission for _____

_____ _____
Parent/Guardian Signature **Date**

Revised: 3/26/2014