|  |
| --- |
|  **Parent / Guardian Name:** |
| **Child’s Name: Date of Birth: Center:** |
| **First Aid**- I understand that PEEC Staff will provide any basic first aid deemed necessary for my child. | [ ]  Yes [ ]  No |  Parent / Guardian Initial:  |
| **Emergency Card**- I understand that in the event of a medical / dental emergency, for which I cannot be contacted, PEEC staff will obtain necessary treatment. This authorization includes my consent for my child to receive treatment by a physician / dentist in any hospital or emergency department.  | [ ]  Yes [ ]  No |  Parent / Guardian Initial:  |
| **Health Record Transfer**- In an emergency, I hereby authorize the transfer of my child’s health care record to the local hospital. | [ ]  Yes [ ]  No |  Parent / Guardian Initial:  |
| **Sunscreen Use**- I grant PEEC permission to apply sunscreen, SPF 15 or greater, prior to outside play. Sunscreen will be provided by Head Start. | [ ]  Yes [ ]  No |  Parent / Guardian Initial:  |
| **Transfer of Records** (Kindergarten) - I give my permission for my child’s medical / educational records to be forwarded to my child’s receiving school district at the end of the school year. | [ ]  Yes [ ]  No |  Parent / Guardian Initial:  |
| **Media Release**- I give my permission for my child and / or family members to be photographed and / or videotaped during Head Start activities :* For classroom and center use
* For promotional purposes. (Materials used for promotional purposes may include your child’s first name and age)
 | [ ]  Yes [ ]  No[ ]  Yes [ ]  No |  Parent / Guardian Initial:Parent / Guardian Initial: |
|  |  |  |
| **Consent For Health Screenings**  |
| I give my permission for my child to receive the following screening evaluations:Hearing & Vision Screen Height & Weight Measurements Blood PressureI understand that these services are considered necessary by the Head Start Program and that I will be informed of the results.   Parent / Guardian Initial: Date:   |
| **Permission for Developmental Screenings:** |
| I understand that Head Start will screen my child for potential developmental concerns. Screenings assess children’s physical, cognitive, language and social-emotional skills. I understand that by signing this consent that this is only a screening; not a formal evaluation of my child. All information will be kept confidential, results will be shared with you.Signature of Parent / Guardian: Date: |
| **Permission for Mental Health consultation and observation:** |
| I understand that Head Start will work with mental health consultants to conduct individual child and classroom observations to support children’s social and emotional well-being. Results will be shared with you following an individual child observation. All information will be kept confidential.Signature of Parent / Guardian: Date: |
| **Keep Informed** |
| PEEC will send occasional updates such as school closures and meeting reminders via text and email. Please provide the following contact information below : |
| **Name: Text #: Email:** |
| **Name: Text #: Email:** |
| **Staff Verification** |
| By signing, the staff member acknowledges verification and / or explanation of purpose and intent of the information contained in these pages, and that these consents are valid for 1 year from the date signed.Staff Member Signature : Date: |