|  |  |  |
| --- | --- | --- |
| **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 Pressure  I 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: | | |