Charlotte County Public Schools
Early Childhood Programs
Head Start/Early Head Start
(941)575-5470
(Appendix 21)

Dear Parent/Guardian,

The Health Advisory Committee recommends that the following health services be provided to every child. These screenings will be used to provide any additional educational, health or special services you may need. You will be notified of any results that may require additional evaluation or treatment.

Growth Assessment	Vision Screening
Hearing Screening	Dental Exam
Speech Screening	Developmental Assessment
Lead Assessment	Hemoglobin/Hematocrit Determination

Has your child ever been to a dentist? _____ If "Yes", when _____

Dentist's Name: _____ Do you have Dental Insurance? _____

Please sign the consent form below, indicating that you understand the Notification/Consent/Release policy and give permission as follows. Please indicate your permission by **initialing** each area that you are approving.

CONSENT:		**RELEASE:**	
WIC	_____	Hemoglobin Count	_____
Health Screenings/Assessments/Follow up	_____	Health/Nutritional Records	_____
Dental Exam/Follow up	_____	Educational Records	_____
Developmental Assessment/Follow up	_____	Family Support Plans	_____
Photograph for Medication Administration	_____	Ind. Family Service Plans	_____
Transport child in an emergency/Dental Visit	_____	Other _____	_____

I understand the policy listed above and I am giving my permission/consent for all areas I have initialed. I understand that this agreement is valid for the duration of my child's enrollment in the Early Childhood Programs.

Child's Name: _____ DOB: _____

Parent/Guardian/Caregiver Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Distribution: Family Service Worker Parent Community Health Advocate