Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

CHILD/FAMILY SERVICES
CONSENT FORM

Child's Name: _____
Last First

Facility: _____ Date of Birth: _____/____/____ Sex: ___M ___F

I GIVE CONSENT:	***Screenings / Activities:***	**Y**	**N**
That my child, _____, may participate in the Screenings/Activities listed on the right. I understand that the Head Start Program requires that each child has completed health/dental screenings. I understand that the screenings listed have been explained to me and I understand that the screenings listed will be conducted at the center/FCCH/ Home Base Parent Socialization Events and are for information only. (Developmental screenings and ongoing assessments may include speech and language, cognitive, social emotional, fine/gross motor and ongoing developmental assessment.)	Hearing Screening	☐	☐
	Vision Screening	☐	☐
	Hemoglobin or Hematocrit	☐	☐
	Height/Weight Measurement	☐	☐
	Fluoride Varnish	☐	☐
	Fluoride Toothpaste	☐	☐
	Dental Exam by Licensed Dentist	☐	☐
	Tuberculosis Risk Assessment	☐	☐
	Blood Pressure	☐	☐
	Developmental Screenings	☐	☐
	Nutrition Referral	☐	☐
	Mental Health Consultant Services	☐	☐

I GIVE CONSENT:	**Y**	**N**
1. That my child may go on all field trips taken by the program, provided that I have received information about the specific trip, date, destination, time of departure and return prior to each trip. I understand that children will be accompanied by educators, facility staff, and volunteers. I may also attend.	☐	☐
2. That the Head Start Program has the right and permission to copy and publish photographs, video tapes or pictures of my child. The photograph/video, whole, in part, or composite, may be used as the program sees fit on publication of educational material, advertising thereof, or for any other lawful purpose for an indefinite amount of time.	☐	☐
3. That when my child is ready to leave the program, I request that his/her health/education records be transferred to the receiving school.	☐	☐
4. To allow agency staff to make home visits during the school year at MY CONVENIENCE.	☐	☐

I have exceptions/explanations to above items or to other considerations (i.e., holidays, etc.):

_____
_____

INFORMED CONSENT

I have read the foregoing and the above answers are true and complete to the best of my knowledge and belief. I understand that if any of this information changes, I am obligated to notify this program immediately. I understand the information provided above will remain strictly confidential.

_____ _____
Signature of Parent or Guardian Date Signature of Staff Date

Distribution: White – Child's File Yellow – Health Pink - Parent