Revised: 3/2017

PARENT AUTHORIZATION FORM

CHILD'S NAME: _____

1. I give permission for my child to receive the following screenings and follow-up services: Vision, Hearing, Speech, Classroom Observations, Lead, Hematocrit/Hemoglobin (from doctor or WIC), Child Social/Emotional Assessment (DECA), and Child Social/Emotional Observation Checklist, as well as ESI, the Bayley.
   - o YES
   - o NO
2. I give permission for my child to receive dental exams and follow-up services by the Children's Dental Clinic, needed for the participation in the Head Start Program.
   - o YES
   - o NO
3. I give permission for my name and telephone number to be listed on the parent roster. This roster shall be available to any custodial parent/guardian.
   - o YES
   - o NO
4. I give permission for my child's photograph to be used:
   - o Classroom Photos
   - o Newspaper photos
   - o Brochure photos
   - o Agency Classroom Newsletters
   - o Agency's Facebook Page / Agency Website
   - o Classroom Instagram Page
   - o Agency Display Boards
   - o Other parent/guardian's in the classroom
     - ➢ We are not always able to prevent cell photos from being taken, though we do restrict cell usage in our classrooms and during activities
5. I authorize Coshocton County Head Start/Early Head Start to obtain & release the following information on my child's behalf***: Screening Results, Medical Results, Physicals, and Dental Results.***
   - o YES
   - o NO
6. I give permission for routine transportation of my child to and from HEAD START.
   **Early Head Start does NOT provide transportation.*
   - o YES
   - o NO

Parent Signature: _____ Date: _____

2nd Yr. Signature: _____ Date: _____

3rd Yr. Signature: _____ Date: _____