Consent for Emergency Medical/Dental Treatment

Center ___________________

This form must be completed by the legal guardian of the enrolled child prior to any services for an emergency medical or dental treatment being performed and must accompany the child to the services provider.

I, __________________, hereby give my authorization for my child, _____________, to receive Emergency Medical or Dental Treatment to my child by any licensed physician or dentist while under the care of Central Mississippi, Inc., Head Start Program and for the transport of the child to any from the source of emergency treatment.

This care may include examinations and any tests which in the opinion of the physician or dentist are deemed necessary or advisable.

This does not include the right to perform surgical operations without any further consent, except in the case of an emergency and only after an diligent effort has been made to locate me and I am not available.

This consent is valid for school year ____________ to ____________. The purpose of this consent has been explained to me.

I certify that this form has been explained to me and I agree to the terms and conditions contained herein.

______________________________ ________________

Signature of Parent/Guardian Date

______________________________ ________________

Signature of Staff Date

Assurance of Confidentiality: All of the information you provide helps us to deliver services most appropriate for your family needs. You may prefer not to share some information with us. However, some information is required to determine eligibility. All information is held in strict confidence.

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