Parent Consents, Authorization and Release Form

Center: _____

My signature below authorizes my child, _____, to participate in the health screening checked and initialed below that are conducted by Central Mississippi, Inc., Head Start/Early Head Start Program as a part of its comprehensive service to my family. I further understand that prior to any treatment resulting from screening being performed; Central Mississippi, Inc., Head Start/Early Head Start will contact me for authorization for treatment and other services.

These consents, authorizations and releases are valid for school year _____ to _____. The purpose of this consent has been explained to me.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Screening:
Please check and initial each authorized screening:

Screening	Parent's Initial
☐ **Hearing Screening**	
☐ **Height & Weight**	
☐ **Vision Screening**	
☐ **Behavior Screening**	
☐ **Speech/Language Screening**	

Release:
☐ My child's record may be shared with appropriate professionals or service agencies.

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.

Revised 02/2008