CONSENT FOR CHILD TO RECEIVE MEDICALSERVICES/ FOLLOW-UP TREATMENT

CENTER _____ CHILD'S NAME_____

I_____, hereby give my consent _____, or I do not give my
(Yes)

consent _____ for _____ to receive the following type or types of
(No) **(Child's Name)**

treatment: _____

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and for the transport of the child to and from _____
(Name of Provider)

_____ on _____.
(Location) **(Date)**

I understand that a medical provider has recommended this treatment as necessary or advisable for your child, and I understand the nature of treatment. The purpose of this Consent Form has been explained to me. This Consent is valid for school year _____ to _____. By signing this consent, you agreed for Central Mississippi Head Start staff to accompany and transport your child to this medical provider.

_____ _____
Signature of Parent/Guardian **Date**

I have explained to _____ the purpose of this consent and the
Name of Parent/Guardian

nature of the services/treatment recommended for the child listed above.

_____ _____
Signature of Head Start 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.