

**Randolph County Board of Education Head Start
Denial of Consent for Medical / Dental/ Special Services**

Medical ____ Dental ____ Special Services ____

As parents or legal guardian of _____

Name of Child

It is my desire that no _____ be provided to my child by Head Start. I understand that this treatment has been recommended and that it will be provided free of charge. I accept the consequences of this action/ dental/ and in no way hold Head Start responsible for any future medical/Dental/ Special Services problems resulting from lack of treatment.

Parent / Guardian

Date

Head Start Representative

Date