Randolph County BOE Head Start

Consent to obtain and/or release health and dental information

Child's Name _____DOB _____

I, _____, give permission to obtain and/or release results for all medical and dental screenings, examinations and treatments regarding my child to and from Randolph County BOE Head Start Program. All Information will be held in strict confidence.

Health Provider/Agency
_____
_____
_____

_____/_____/_____
Parent/guardian's signature Relationship to child Date

_____/_____
Signature of Head Start Staff Title