

Randolph County BOE Head Start

Consent for Required Screening

Child's Name _____ **DOB** _____

I, _____, give permission for my child to receive all required screening as listed below. This information will be used to provide additional follow-up or special services my child may need while enrolled in Head Start. I understand that I will be notified of screening results and needed follow-up as required. *(If you wish to refuse a requirement, please circle it).*

- | | | |
|----------------------------|-----------------------------|--------------------------------------|
| <i>Vision Screen</i> | <i>Hearing Screen</i> | <i>Speech Screen</i> |
| <i>Height & Weight</i> | <i>Developmental Screen</i> | <i>Social/Emotional Observations</i> |
| <i>Dental Examination</i> | <i>Physical Examination</i> | |

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

_____/_____
Signature of Head Start Staff Title