1 Copy to Teacher
1 Copy to FDS

Community Action of Southeast Iowa Head Start/Early Head Start Screening/Consent Form

Child's Name_____ Date of Birth_____

I hereby give my permission for my child to: (parent must initial all that apply)

- Receive the following screenings:

Speech	_____	Dental	_____
Hearing	_____	Social/Emotional	_____
Vision	_____	Developmental	_____
Height/Weight	_____	Lead	_____
Blood Pressure	_____	Hemoglobin	_____

- To avoid unnecessary retesting, the Health Department, WIC Program, or my child's physician may be contacted to obtain any screening information listed above. _____
- Have sunscreen applied by HS/EHS staff _____
- Have diaper ointment applied by EHS staff (EHS children only) _____
- Be transported to dental/medical appointments _____
- Be included in photographs and videos used for classroom display purposes, classroom activities and HS/EHS training use _____
- Participate in all scheduled field trips _____
- For my child's classroom to be observed by various community organizations including, but not limited to: child care workers, high school/college students, health professionals, educators, business or service groups and consultants _____

_____ __/__/__ _____ __/__/__

Signature Parent/Guardian Signature Staff Witness

This consent will be in effect for the 2020-2021 School Year
Rev. 1/20 HS5016A