Community Action of Southeast Iowa Head Start

Parent Permission & Release

NAME OF CENTER _____ **TEACHER** _____

CHILD'S FULL NAME _____ **DATE OF BIRTH** _____
First Middle Last

CHILD'S HOME ADDRESS _____
(Include city/town)

I give permission to allow Community Action of Southeast Iowa to text and/or email information regarding my child and/or the Head Start/Early Head Start program. Community Action of Southeast Iowa will not be held liable for any cost associated with incoming or outgoing text messages. Community Action of Southeast Iowa will not be held responsible for any information released to the phone number or email address listed below if I fail to notify staff of a phone number or email address change.

Phone Number: _____ **Email Address:** _____

By signing this form, I also give permission for my child to ride the Head Start bus (if available) and for the Head Start staff to sign my child in and out of the center each day.

PICK UP ADDRESS _____ **PHONE** _____
(Include city/town)

DROP OFF ADDRESS _____ **PHONE** _____
(if different) (Include city/town)

If a non-adult will be picking up a child from the center or getting a child off the bus, a *Parent Authorization of Youth Pick up and Release Form* must be submitted to the Family Services Coordinator for prior approval.

PLACE IN ORDER OF PREFERENCE: (List additional names on the back of this form)

NAME	**RELATIONSHIP**	**TELEPHONE**	
1.	*Parent/Guardian*	**home**	**work**
2.	*Parent/Guardian (if applies)*	**home**	**work**
3.		**home**	**work**
4.		**home**	**work**
5.		**home**	**work**
6.		**home**	**work**
7.		**home**	**work**
8.		**home**	**work**

I hereby give permission for my child to leave the center with/or be released to the persons named above, it is my responsibility to notify the center, in person, of any changes to this list.

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center? **(Must have copy of court order stating the above)**

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

_____ / / _____ / /

SIGNATURE PARENT/GUARDIAN **DATE** **STAFF WITNESS** **DATE**

This form will be valid for the 2022-2023 School Year
Rev. 2/2022 JH HS5016 B

Assigned FDS _____

FDS
3 Copies to Lead Teacher
1 Copy to Bus Transporters

Community Action of Southeast Iowa Head Start/Early Head Start

EMERGENCY MEDICAL RELEASE

*This form is to go with child if transported for emergency care

Child's Full Name_____ **Date of Birth**_____
First Middle Last

Sex of Child: ☐ **Male** ☐ **Female** **Parent/Guardian** _____

Physician_____ **Physician Telephone Number**_____

Dentist_____ **Dentist Telephone Number**_____

As parent or legal guardian, I give my permission for my child to receive emergency medical or dental care provided by a local doctor, dentist, or emergency room physician. In addition, I authorize Community Action of Southeast Iowa Head Start/Early Head Start staff to administer first aid to my child as deemed necessary.

I agree to pay the entire costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent. Every effort will be made to notify parent/guardian immediately in case of emergency. This form will be presented upon admission for treatment.

Allergies to medications or food: _____

Medications child is currently taking: _____

Insurance Company_____ **Policy Holder's I.D.**_____

Religious Preference (optional) _____

_____ __/__/__ _____ __/__/__
Signature Parent/Guardian Date Signature Staff Witness Date

_____ __/__/__
Nurse Signature Date

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 _____

I give permission for Community Action to share my information with internal databases for the purposes of data reporting and providing services to assist my household. This sharing of information is to be conducted with maximum respect for the confidentiality of participant information.

_____ __/__/__
Signature Parent/Guardian

_____ __/__/__
Signature Staff Witness

This consent will be in effect for the 2022-2023 School Year
Rev. 2/22 HS5016A

Head Start
& Early Head Start
Community Action of Southeast Iowa

Media Consent

I, _____ the parent/guardian of
(Parent/Guardian Name)

_____ make the following determination about
(Child's name)

Community Action of Southeast Iowa Head Start and Early Head Start and the use of photos/videos taken of myself and my child, within the Head Start and Early Head Start Program. Photos/videos may be used for publications to promote the Head Start and Early Head Start program (examples: printed materials like flyers, TV/Newspaper and/or online publications like Facebook/Twitter/website).

I understand that if I decide that I no longer wish for pictures to be used in any publications, I must contact Community Action directly to notify them. I will contact the following person at the following phone number and/or address:

Jill Hulett
Family Services Coordinator
2850 Mt. Pleasant Street, Suite 108
Burlington, IA 52601
319-753-0193

_____ I give permission to use photos/videos _____ I do not give permission

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

CC: Parent/Guardian, Child's File, ChildPlus

7/2020 JH

Community Action
OF SOUTHEAST IOWA

Release of Information for Outside Agency

I _____ give Community Action of Southeast Iowa Head Start/Early
Parent/Guardian (please print)
Head Start staff permission to release and exchange information (check all that apply):

- ☐ Behavior reports, incident reports, brigance scores, social-emotional questionnaire results, any classroom information
- ☐ Disability Information
- ☐ Education Records
- ☐ Special Education Records
- ☐ Health Information
- ☐ Hearing Screening Results
- ☐ Mental Health information
- ☐ Agency/person to observe or that has observed my child in a classroom setting
- ☐ Other_____

Regarding my child, _____
Child's Name (please print) Date of Birth

To/from Great Prairie Area Education Agency (AEA)
(Print name of other Agency or Health Care provider)

This release is to remain in effect from today's date (as indicated next to my signature) until one year from today.

All the above information has been explained to me and all my questions regarding this release have been answered to my complete satisfaction.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Address Phone #

_____ _____
Staff Signature Date

HS 5019b (rev 2/22)

Community Action OF SOUTHEAST IOWA

Release of Information For Outside Agency

I _____ give Community Action of Southeast Iowa Head Start/Early
Parent/Guardian (please print)
Head Start staff permission to release and exchange information (check all that apply):

- ☐ Behavior reports, incident reports, brigance scores, social-emotional questionnaire results, any classroom information
- ☐ Disability Information
- ☐ Health Information
- ☐ Mental Health information
- ☐ Agency/person to observe or that has observed my child in a classroom setting
- ☐ Other_____

Regarding my child, _____
Child's Name (please print) Date of Birth

To/from_____
(Print name of other Agency or Health Care provider)

I am aware that if I do not want to continue to have my child's information released to the above mentioned person, I am responsible to void this release by contacting my Family Development Specialist and/or my child's nurse or teacher.

This release is to remain in effect from today's date (as indicated next to my signature) until one year from today, unless I choose to void this release beforehand.

All the above information has been explained to me and all my questions regarding this release have been answered to my complete satisfaction.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Address Phone #

_____ _____
Staff Signature Date

HS 5019b (rev 2/22)

Head Start & Early Head Start
Community Action of Southeast Iowa

Release of Information

I _____ give Community Action of Southeast Iowa Head Start/Early
Parent/Guardian (please print)
Head Start staff permission to release (check one):

☐ ANY information

or ☐ ONLY the following information:_____

_____

regarding my child, _____
Child's Name (please print)

to _____.
(Print name of interested party)

Their relation to my child is _____.
(i.e. parent, step-parent, grandparent, aunt/uncle, child care provider etc.)

I am aware that if I do not want to continue to have my child's information released to the above mentioned person, I am responsible to void this release by contacting my Family Development Specialist and/or my child's Teacher.

This release is to remain in force from today's date (as indicated next to my signature) until one year from today, unless I choose to void this release beforehand.

All the above information has been explained to me and all my questions regarding this release have been answered to my complete satisfaction.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Staff Signature Date

University of Iowa
Stead Family
Children's Hospital

Iowa KidSight
Consent Form

Date of Screening:_____

Has this child seen an eye doctor within the last year? ☐ No ☐ Yes

If yes, the screening is not necessary. Continue appointments with your eye doctor.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at the University of Iowa Stead Family Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus (misaligned eyes), and media opacities (e.g., cataracts). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for children 6 months of age through Kindergarten. Children who are younger than 6-months old will not be screened. No child will be screened without a signed and completed consent form. Each individual child needs his/her own consent form. If you have questions, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, or 319-353-7616, or kidsight@uiowa.edu.

Please print or type the information below:

Child's Name _____ (_____)
First Middle Last Initials

Male _____ **Female** _____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YY)

Parent's Name _____

Address _____ **City** _____ **Zip** _____

Home Phone (_____)_____ **Work Phone** (_____)_____

Cell Phone (_____)_____ **E-mail address** _____

I, the undersigned, hereby give permission for my child, _____, to participate in the screening event. I understand the following regarding this program:

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. I will be contacted with the results of the screening through Iowa KidSight at the University of Iowa Stead Family Children's Hospital, or through my child care provider who aided in arranging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff.
3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
4. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Iowa KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
6. Iowa KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Stead Family Children's Hospital, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

_____ _____
Signature of Parent or Guardian **Date**

Revised 1-2017

Community Action
OF SOUTHEAST IOWA

2022-2023 School Year

Dear Parent / Guardian:

As you and your child are getting ready for Head Start preschool, there are several health items that the Head Start program needs from you. The following items will need to be completed so that your child will be ready to begin preschool:

- **PHYSICAL EXAM** from you child's physician completed within the last 12 months. If you cannot get into the doctor before your child begins preschool, please bring a copy of your appointment time and date to give to the Family Development Specialist at Head Start.

- Your child's current **IMMUNIZATION RECORD**.

- **DENTAL EXAM** completed by your child's dentist with in the last 12 months. If you cannot get into the dentist before your child begins preschool, please bring a copy of your appointment time and date to give to the Family Development Specialist at Head Start.

Your child will be screened for hearing, vision, height, weight, and blood pressure once your child begins preschool.

The physical and dental exams are covered under Title XIX and are available at Community Health Centers of from those doctors that accept TITLE XIX. If you need assistance locating financial aid for payment of these exams or require transportation, please notify the Family Development Specialist who will assist you.

If you have questions or need assistance in making doctor or dentist appointments, please call the Community Action Head Start preschool center and speak to the Family Development Specialist. If you have further questions, you may call me or Leah Haberichter, Health & Nutrition Services Coordinator, at the number below.

Sincerely,

Matthew LeClere

Head Start Director

319-753-0193

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE –
OR PROVIDE COPY OF WELL CHILD PHYSICAL

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr.:_____

Hgb or Hct- @ 12 mo.: _____

Lead Risk Assessment: _____

Blood Lead Level: date_____ results _____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:

(n = normal limits) otherwise describe

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at the child care facility: (include *over-the-counter* and *prescribed*)

Medication Name — Dosage

☐ Diaper crème:
☐ Fever or Pain reliever:
☐ Sunscreen:
☐ Other

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Additional Referrals made:

☐ _____
☐ _____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(Please complete and give to parent for child care)

Comments:

May use stamp

Signature _____
Circle the Provider Type: **MD DO PA ARNP**

Address: Telephone

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

NATIONAL CENTER ON
Early Childhood Health and Wellness

Early Childhood National Centers

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

This document was prepared under grant #90HC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Early Childhood Health and Wellness.