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