Charleston County SCHOOL DISTRICT excellence is our standard

Head Start Birth to Age 5

Consent/Refusal and Release of Information Form

Child's Name _____ Date of Birth _____
Parent/Guardian Name _____ Telephone _____

Home Address: _____

Medicaid Type _____ Medicaid # _____
Private Insurance _____ Policy # _____ Cardholders Name/DOB_____

Please **initial** each line item, **sign** and **date** below:

_____ A. I hereby give my consent for Charleston County School District Early Head Start/Head Start Program to screen my child for growth assessment, blood pressure, speech, vision, hearing, developmental, and behavioral. I understand that the results of the screening will be used to assist in the educational and health programming for my child and this data, as well as any other health or nutrition information on my child, will be available to me. If you wish to deny consent of a specific screening, please check below.

_____ a. I **deny** consent for the following screenings to be completed by CCSD HS/EHS Program: (check only those you wish **not to have completed**)
_____ Growth Assessment _____ Blood Pressure _____ Hearing _____ Vision
_____ Developmental _____ Behavioral _____Speech

_____ B. I hereby give my consent for Charleston County School District Early Head Start/Head Start Program to obtain or arrange for my child to receive physical examination (unclothed with HS Staff supervision), dental examination, blood lead, hemoglobin, audiology exam, eye exam, or mental health assessment to be completed by a licensed medical or dental provider, or laboratory technician, as required by the Head Start Performance Standards, if up-to-date information has not been provided by the parent/guardian within specified timeframe.

_____ a. I **deny** consent for the following to be obtained or arranged by CCSD HS/EHS Program. I understand by denying, I will be responsible for providing this information as required by HSPS 1304.20 (a-b): _____ Physical Exam _____ Dental Examination _____ Vision Exam
_____ Audiology Exam _____ Laboratory blood work _____ Mental Health Assessment

_____ C. I consent for CCSD HS/EHS or a contracted Community Partner completing any examination or lab work as part of the requirement for the Head Start Performance Standards, to bill my child's Medicaid or Private Insurance. If insurance is denied for any reason, I understand I will not personally receive a bill for the completed service.

_____ D. I hereby give my consent to Charleston County School District Early Head Start/Head Start Program to receive and/or share necessary information to/from any medical or dental facility and other agencies as may be required under the law, in reference to my child in order to provide all the necessary screenings, examinations, and services required by the Head Start Performance Standards.

_____ E. I hereby give my consent for emergency medical or dental treatment to be provided to my child by any licensed physician, dentist, any other qualified healthcare provider, or trained persons, while under the care of the Early Head Start/Head Start Program, and also consent for my child to be transported to and from the source of the emergency treatment.

_____ F. I hereby authorize Charleston County School District Early Head Start/Head Start Program to transport my child for the purpose of obtaining required medical and dental information, emergency treatment, or follow-up.

School Term: _____ Parent Signature _____ Date Signed_____

As a parent/guardian of a returning child to CCSD HS/EHS, I hereby continue to give permission for the above signed consents from the previous school term(s).
School Term #2: _____ Parent Signature _____ Date Signed _____
School Term #3: _____ Parent Signature _____ Date Signed _____