

Area Five Agency Head Start
Parent Consent for Health Procedures

Child's Name: _____ Teacher: _____

Directions: Initial next to each procedure if consent is given. Full parent signature required at bottom of page.

_____ **Vision Screening:** I hereby authorize and request that Head Start provide vision screening for my child. I understand this is only a screen, not a full eye exam, and I will be notified of the results. *If child is already under the care of an eye doctor or wears glasses, please have Head Start's Eye Exam Form filled out by the examining eye doctor and turned in to Head Start by the child's 30th day of enrollment.*

_____ **Lead Screening:** I hereby authorize and request that Head Start obtain a blood sample from my child to determine if there is an elevated level of lead. By law, my child's name, address, and demographic information concerning the concentration of lead in the blood must be reported to the Indiana State Department of Health, the Family Social Services Administration, the local health department, and the Federal Department of Health and Human Services to ensure that children potentially affected by lead-based paint and lead hazards are adequately protected from lead poisoning. I understand that I will be notified of the results, and results may be shared with my child's physician. *The Health Manager will only perform this screening for children who are not already up-to-date on this screening, as shown in child's health records.*

_____ **Hemoglobin Screening:** I hereby authorize and consent that Head Start obtain a blood sample from my child to provide hemoglobin screening. I understand that I will be notified of the results, and results may be shared with my child's physician. *The Health Manager will only perform this screening for children who are not already up-to-date on this screening, as shown in child's health records.*

I certify that these procedures have been explained to me by Head Start staff, and I give consent for the procedures I have initialed above.

*Parent signature: _____ Date: _____

REFUSAL OF HEALTH PROCEDURES

I *refuse* to have the following health procedures completed for my child:

Please state reason: _____

Parent Signature: _____ Date: _____