

CONSENT/COMMENTS FORM

CHILDS NAME: _____ BIRTH DATE: ____ / ____ / ____ COMMUNITY: _____

I GIVE permission for my child to:

1. Have his/her photo used in newspapers, books, or displays for educational purposes and/or publicity. Yes No
2. Have reflector tape ironed onto my child's jacket at the Head Start Center Yes No
3. Have his/her records transferred to the school district for kindergarten transition. Yes No
4. Participate in Vision Screenings and/or the Screening Camera. Yes No
5. Participate in Hearing Screenings Yes No
6. Participate in Height/Weight Screenings Yes No
7. Participate in Dial 3/Development Screenings Yes No
8. Participate in field trips as long as I/we are notified of the destination and date. Yes No

I GIVE permission:

9. That my phone number may be provided to parent committees for Head Start activities. Yes No

Parent Signature: _____ Date: _____

**BBNA Head Start
Consent for Medical Treatment**

This authorizes _____, Teacher, or _____, Teacher Aide, or _____, Bus Driver, to give consent for emergency medical treatment including emergency surgery for my child, _____, in the event that neither parent/guardian is available at the time such consent is needed.

This consent will be in effect between _____ and _____.

Parent/Guardian Signature: _____ Date: _____