nmcaa
Head Start/Early Head Start

Release of Health Information

Great Start Readiness Program

As Parent/Guardian of _____, born _____,

Please Print Child's Name Child's Date of Birth

I hereby request and authorize Northwest Michigan Community Action Agency's Child Development Program and/or Intermediate School District Child Development Program to access my child's health screening which may include; most recent well-child exam, hearing screening, vision screening, blood pressure, hematocrit/ hemoglobin, growth assessment, blood lead screening, immunizations record, any other health referrals/ recommendations. These records will be used to meet the Head Start Standards and Michigan Child Care Licensing Rules in order to participate in preschool programming and support each child's growth and school readiness. Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

_____ Last or Next Exam Date

_____ Medical Provider and/or Office

_____ Phone Number

_____ Address / City

_____ Parent/Guardian: Signature

_____ Printed Name

_____ Date

Not to exceed two years from the signature date, or upon exit of the program.

☐ Yes, I give permission for the Program Staff and/or Health Department to conduct hearing, vision, blood pressure, or non-invasive hematocrit and growth assessment screenings on my child if needed to complete the Head Start Health Requirements. I understand that I will receive the results of the screenings.

☐ No, I do not give permission for the Program Staff and/or Health Department to conduct the above screenings. Please explain why:_____

_____ Parent/Guardian: Signature

_____ Printed Name

_____ Date

Not to exceed two years from the signature date, or upon exit of the program.