****

**Rock -Walworth Comprehensive Family Services, Inc.**

Head Start and Early Head Start

1221 Henry Avenue, Beloit WI 53511 **Phone:** (608) 299-1500 or 1-800-774-7778 **Fax:** (608) 299-1629

**Parent/Guardian Permission to Provide Required or Beneficial Screenings/Testing**

Information sharing regarding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Last Name First Name MI Date of Birth**

Name of parent/guardian authorizing release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Last Name First Name MI Date of Birth**

**Dear Mothers, Fathers or Guardian/s,**

**In order to meet required federal performance standards, and as schedules and budgets allow we provide a health, social/emotional and oral health wellness program throughout the year that may include:**

1. Oral health exams and fluoride varnish applications provided by local licensed dentists and hygienists.
2. Hearing and Vision Screenings provided by local health department nurses or trained RWCFS staff
3. Obtainment of lead level and/or hemoglobin information from a child’s physician, local WIC programs or the Wisconsin Lead Registry before obtaining levels while the child is at school.
4. When unable to obtain lead and hemoglobin levels in other ways, lead level and hemoglobin testing by community medical professionals. Because this requires pricking a child to obtain a small amount of blood, RWCFS will send home a separate permission request if/when a lead level or hemoglobin test is needed.
5. Observations and/or social/emotional or sensory screenings completed by a licensed professional (Mental Health/Wellness Consultant). **This professional primarily provides observations of children’s’ behaviors or, concerns expressed by staff or parents and provides recommendations to support staff and parents in working effectively with all children.**
6. Developmental screenings

If you would like your child to participate in this program and receive any or all of these services, please sign and date for your permission below.

RWCFS strives to provide these services for each participating child, however, if you DO NOT want your child to receive any of the services listed in the box above, Circle their assigned number(s) here:

1 2 3 4 5

**Please fill in your child’s insurance card number (if your child receives Badger Care, Medicaid or Medical Assistance insurance) in order to support the community professionals stated above. In order to continue these wellness services for our children these professionals sometimes need to be able to bill Medical Assistance. Be assured this information will be shared ONLY with the community professionals stated above.**

**MY CHILD’S BADGER CARD NUMBER IS: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_\_.**

**This permission will be valid for the current program year (as stated with signature below) Sept. 1 through August 31, unless otherwise stated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**This information is confidential and will be used to support programming which meets this child’s unique needs and goals.**

I release the Rock-Walworth Head Start/Early Head Start Program and its staff, outside agencies and staff, from any legal liability for performing services in collaboration with community professionals or professional contracted consultants which I have permitted by signing this form for the period stated above. This permission may be withdrawn, in writing, at any time by the person signing this form, except to the extent that service has already been in reliance upon authorization. Withdrawal of the authorization will be effective following receipt of the written request by RWCFS Head Start/Early Head Start.

**Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **(1/11)**