HEAD START
City of San Antonio
Department of Human Services

Child's Name: _____

ChildPlus ID#: _____

Permission for Services

The Head Start program requires permission for services for your child and will work with you and your family to facilitate the completion of these services.

By signing below I understand that:

By choosing "Yes," I give permission to the Head Start Program to provide the specified services.

By choosing "No," I do NOT give permission and decline the services offered by the Head Start Program. I understand that I WAIVE my rights to these specified services and that I will be responsible for obtaining these services for my child.

Permission for Specific Health Services

I give permission and understand that my child will receive emergency medical and/or mental health treatment from a physician, dentist, registered nurse or other certified or licensed health care worker in the event of a critical illness, injury, or crisis. ☐ **Yes** ☐ **No**

I give permission for my child to have medical and behavioral/developmental screenings completed by qualified professionals as required by Head Start Performance Standards. These include, but are not limited to, Hearing, Vision, Growth Assessment, and Blood Pressure. ☐ **Yes** ☐ **No**

Permission for Photography/Videography

I give permission for my child to be photographed, videotaped and/or voice recorded while a student at Head Start. ☐ **Yes** ☐ **No**

I give permission for my child's picture/video to be published in the newspaper, a magazine, the school website, or other publication, including use online for educational purposes and may be shared on public social networking sites. ☐ **Yes** ☐ **No**

I understand that the program will not use any personal information with the pictures, video or voice recordings such as name, age, or location. ☐ **Yes** ☐ **No**

I understand that I will not receive any compensation for the use of the pictures. ☐ **Yes** ☐ **No**

Permission for Text/Email Communication

I give permission for program staff to contact me via text message. ☐ **Yes** ☐ **No**

I give permission for program staff to communicate with me via e-mail. I understand that this includes, but is not limited to, information about my child, attendance, classroom, Ready Rosie, and campus, and program events. ☐ **Yes** ☐ **No**

Wellness Support

I give permission for mental health consultation services, including classroom observations, conducted by a licensed mental health professional to support child, family, and school success as required by Head Start Performance Standard 1304.45. ☐ **Yes** ☐ **No**

Privacy Notification: *I understand that I have the right to request and to be informed about information collected by the Head Start program. I understand that I am entitled to receive and review the information upon request. I also understand that I have the right to ask the Head Start program to correct any information that is determined to be incorrect. I also understand that I may permit or restrict the release of this information. I am aware that I can request a copy of the Notice of Privacy Practices from contract services by contacting the Head Start program.*

I understand that the permissions I grant under this form will remain in effect so long as my child or children are enrolled in the Head Start Program, and that I can revoke the permission, in writing, at any time.

Parent/Guardian Signature: _____ *Date:* _____

I have reviewed and explained the information above to the parent/guardian.

Head Start Staff Signature: _____ *Date:* _____