DELTA HEAD START
CONSENTS AUTHORIZATIONS AND RELEASES

Child's Name _____ Date of Birth _____ Date Completed ___/___/___

I HEREBY CONSENT TO THE FOLLOWING SCREENINGS FOR MY CHILD: Please Initial and sign:

Vision Screening_____ Hearing Screening _____ Speech_____ Physical_____ Dental_____ Lead (finger prick) ____
Height & Weight (3x) _____ Developmental Screening_____ Ongoing Developmental Assessment_____
Mental Health Observation_____ Nutritional Assessment_____

I HEREBY GIVE DELTA HEAD START PERMISSION TO:

Share health, developmental and education records with the public-school system_____
Accompany class on field trips_____ ☐Provide daily application of toothpaste with fluoride_____

Legal guardian signature _____ Date _____

MEDIA CONSENTS AND RELEASES

I give DELTA HEAD START consent to send me text messages/email as it relates to my child and family. I understand that receiving text/email from DELTA HEAD START is voluntary; I will not hold DELTA HEAD START responsible for any charges incurred. I also understand this is a part of their emergency alert system. I may choose to withdraw from the texting/email portion of the program at any time.

_____ _____ _____
Parent Signature Cell Phone Number Email Date

I give DELTA HEAD START permission to publish photos of my child and family. I give them perpetual, royalty free right to use mine or my child (ren) photos in any manner including but not limited to publications and websites. I understand websites have a large audience and my child's photo will be available to the general public, that DELTA HEAD START assumes no liability or responsibility whatsoever concerning any consequences of such use. If I decided to cease participation I will give notice to the Parent Engagement Manager or to the webmaster. If I object to any particular picture on the website, it will be removed as soon as possible. Publication of these photos may include first names for identification purposes.

_____ _____
Parent Signature Date

CONSENT FOR EMERGENCY TREATMENT:

I, the undersigned legal guardian, do hereby request and give consent to the DELTA HEAD START program staff for said child to receive such medical, dental, and surgical treatment as may be deemed necessary and expedient by a licensed physician or dentist in case of emergency when I cannot be reached. In the event of an emergency, I authorize the transfer of my child's health records to the local hospital.

_____ _____
Printed Name of Legal Guardian Signature of Legal Guardian Date
Emergency Contact Number_____

CHILD EMERGENCY HEALTH CARE INFORMATION

Is child covered under SoonerCare? ☐No ☐Yes If yes, what is the Medical ID number_____
If no, would you like assistance in applying for SoonerCare? ☐No ☐Yes
Is your child covered under private or other health insurance? ☐No ☐Yes
Tribal Health Coverage? ☐No ☐Yes
Is dental coverage included on this policy? ☐No ☐Yes
Does this child have a primary care provider? ☐No ☐Yes
Does child have a primary dentist? ☐No ☐Yes

Doctor/Clinic name_____ Telephone_____

Dentist name _____ Telephone_____

CHILD MEDICAL INFORMATION

Date of last Tetanus shot (usually last DTAP):_____
Does child have any allergies to food, medicine, insects, animals, etc.? ☐No ☐Yes
If yes please specify allergy: _____
Is child taking any medications on a regular basis? ☐No ☐Yes If yes, please specify medication: _____
Please describe your child's medical history:
_____
_____
_____