MOUNTAINHEART COMMUNITY SERVICES, INC.
HEAD START/EARLY HEAD START
Consent for Health Screening, Dental Examinations,
EPSDT and PHS Programs

Child's Name: ______________________________ **Birthdate:** _________________________

Center: ____________________________________

I hereby state that my child ____ has ____has not been screened through a clinic under the ESPDT or PHS Programs during the last 12 months.

If screened in the last 12 months, please give the following information:

Name of Doctor/Clinic: ____

Date of Exam: ____

If not screened in the last 12 months, check below if you give consent for your child to receive the screening tests, examinations, and immunizations listed below.

- ☐ Physical Examination
- ☐ Hematocrit (blood test)
- ☐ Partial Urinalysis
- ☐ TB Test
- ☐ Parasites testing (as needed)
- ☐ Vision Test
- ☐ Hearing Test
- ☐ Speech Test
- ☐ Dental Examination
- ☐ Immunizations Needed
- ☐ Behavioral Quick screen

I understand that the screenings are necessary for my child to participate in the Head Start/Early Head Start program, and that I will be informed of the results of all tests and examinations.

Parent/Guardian: ______________________________ Date: ____________________

Original /Central Office File Yellow Copy/Teacher File Pink Copy/Emergency File

Parent/Guardian: ___________________________________ Date: ___________________

Original /Central Office File Yellow Copy/Teacher File Pink Copy/Emergency File