Mahoning Youngstown Community Action Partnership
Head Start/Early Head Start
PARENT/GUARDIAN-SERVICES AUTHORIZATION FORM

_____ _____ _____/_____/_____
Child's Last Name **Child's First Name** **Date of Birth**

Please read and check your authorization for each item below. Your signature at the bottom indicates that you have read and approve all of the items checked yes or no.

☐ **YES** ☐ **NO** **SUPPORT SERVICE/FIELD TRIP AUTHORIZATION**

I give my permission to the childcare center to transport my child on routine field trips that are scheduled throughout the school year. My child will be driven to the park and taken on walks in the vicinity when weather permits, and transported to all medical/dental/speech activities. I understand that all precautionary measures will be taken for my child's safety.

☐ **YES** ☐ **NO** **MEDIA/PRESS/PHOTOGRAPH RELEASE AUTHORIZATION**

I give my permission to the childcare center to take pictures or video films of my child to be used in newspapers, displays, magazines, bulletin boards or in any type of educational publication or for publicity.

☐ **YES** ☐ **NO** **SECURITY CAMERAS**

I give my permission for my child to participate in a facility that has security cameras in the classrooms and/or hallways and outdoor playground area.

INDICATE USING [✓] SCREENINGS, SPEECH EVALUATIONS & SPEECH THERAPY AUTHORIZATION

I give my permission to the childcare center to provide the following screenings I have checked for my child:

- ☐ **Developmental Screening & Assessments**
- ☐ **Lead Screening**
- ☐ **Speech & Language Screening/Evaluation**
- ☐ **Speech Therapy (If Needed)**
- ☐ **Hearing**
- ☐ **Height & Weight**
- ☐ **Hemoglobin-Hematocrit Screening**
- ☐ **Vision Acuity & Exam**
- ☐ **Dental Exam**

☐ **YES** ☐ **NO** **MENTAL HEALTH OBSERVATION AUTHORIZATION**

I give my permission to the childcare center for my child to be part of the classroom mental health observation done twice a year by the contracted Mental Health Consultant.

☐ **YES** ☐ **NO** **RELEASE OF MEDICAL/DENTAL EXAM AND LEAD RESULTS INFORMATION**

I give my permission for_____ and _____ and
{Name of Physician or Clinic} {Name of Dentist or Clinic}
Mahoning County Health Department, Youngstown City Health Department to release medical, dental exams and lead results to MYCAP Head Start/Early Head Start. This permission is valid for up to one year from the signature date below.

☐ **YES** ☐ **NO** **MEDICAL AND DENTAL EXAM AUTHORIZATION**

I give my permission to the childcare center to administer a medical-physical or dental exam to my child provided the exams are done by a licensed physician and dentist. I understand that I will receive notice of the date and times of such examinations.

☐ **YES** ☐ **NO** **ALTERNATE FACILITY AUTHORIZATION**

I give my permission to the childcare center to transport my child to another facility in the event that there is a utility emergency at my child's facility such as the absence of heat, water or electricity.

☐ **YES** ☐ **NO** **RELEASE OF INFORMATION AUTHORIZATION**

I give my permission to the MYCAP Head Start Program to exchange information with **Local School Districts (i.e., Youngstown City Schools, Austintown Schools, Campbell Schools)** and programs such as **WIC, HEAP, Energy Services, Senior Outreach, Help Me Grow and any Partnering Child Care Centers.** I understand that the information will be used for the purpose of providing **additional** services to my child and my family. This permission is valid for up to one year from signature date below.

Parent/Guardian Signature: Date:

Distribution: White: Main File Yellow: Classroom Pink: Health Manual: Transportation Rev.2/11