Elkhart & St. Joseph Counties Head Start Consortium
General Consent/Release Form
Pregnant Moms

Name___________________________________ Date of Birth___________

I GIVE PERMISSION TO:

1. Have my picture taken or video taped this school year in the classroom and/or activities (______) Initials — Yes No
2. To be transported for medical reason, or other reasons, whenever necessary (______) Initials — Yes No

THE EARLY HEAD START STAFF MAY:

1. Release health information to responsible parties (physicians, dentists, etc.) — Yes No
2. Send my health summary to school corporation I will be attending. — Yes No
3. Monitor/review my file. — Yes No
4. Receive relevant health information from doctor, dentist, speech pathologist, eye doctor and/or community agencies or school corporation when requested — Yes No

I UNDERSTAND THAT:

1. Staff will schedule two home visits each year — Yes No
2. I must receive a physical, dental exam and lab work prior to entry date of school year and be current with immunization. — Yes No
3. Current address, home phone number, work address, work phone number and emergency number should be made available to the Early Head Start Program at all times (______) Initials — Yes No
4. I understand that the information disclosed is subject to redisclosure by the recipient and may no longer be protected by the federal privacy regulations, 45 CFR 164 Subpart E. — Yes No

Student Signature: ____

Guardian Signature: ____

Date: ____

PERMISSION EXPIRES ONE YEAR FROM CURRENT SCHOOL YEAR