Parent/Guardian Consent Form

PARENT/GUARDIAN NAME_____

CHILD_____ **DOB**_____
CHILD_____ **DOB**_____
CHILD_____ **DOB**_____
CHILD_____ **DOB**_____

I give consent for the following screenings to be completed by my child's Provider or person designated by the Early Learning Coalition: Developmental, Vision, Hearing, Height & Weight and BMI (Body Mass Index). The results of this screening will be shared with the parent. I am aware that I may withdraw this consent in writing at any time.

Please check one:
I authorize consent. ☐ **I decline consent.** ☐

I give consent to Coalition or contracted staff to engage in verbal, written, or electronic communication about the health, educational, and/or behavioral status of my child or me with the following service providers/community programs. Consent may not be denied for review of information related to federal or state funding payments.

Children's Medical Services
Department of Children & Families
Early Steps (formerly DEI)
Escambia County Health Department
Escambia County School District
Early Learning Coalition of Escambia County
Other:_____

Families First Network
Fl Diagnostic & Learning Resources System
Division of Early Learning
Head Start
VPK program Provider
Employer

Please check one:
I authorize consent. ☐ **I decline consent.** ☐

I am aware that I may withdraw this consent in writing at any time.

_____ **Date**_____
Signature of Parent/Guardian

Authorization is valid for the period the participant remains in the program or withdraws their consent.

A PHOTOSTAT OF THIS SIGNED CONSENT FORM SHALL BE AS VALID AS THE ORIGINAL

Revised 1/10/2022