Educare Winnebago Head Start/Early Head Start Program
Consent for Screenings, Follow-Up, Authorizations, and Permissions/Releases

Date Completed: ____/____/____

Child Name: _____ Date of Birth: ____/____/____
First M. Last

- **Consent for Screenings:**
  - ✓ Physical Exam and Immunizations: Up to Date
  - ✓ Lead Screening #
  - ✓ Heights and Weights
  - ✓ Blood Pressure
  - ✓ Hematocrit and Hemoglobin #
  - ✓ Dental Screen Follow Up/Referrals
  - ✓ Vision Screen Follow Up/Referrals
  - ✓ Hearing Screens/Follow Up/Referrals
  - ✓ Head Checks
  - ✓ Developmental Screen/ Brigance Screen
  - ✓ Mental Health Screen: Parents-ASQSE and Teachers-Observation
  - ✓ Nutrition Screen

- **Other Permission/Releases:**
  - ✓ Transition Health/Enrollment/Education records to the school system
  - ✓ All class field trips and use of child photo
  - ✓ Fluoride Varnish/Xylitol Gum Program
  - ✓ Consent for Emergency Dental and Medical Treatment at IHS
  - ✓ Consent for Medical Records: Health Information/Physical Exam
  - ✓ Consent for Public Health Nursing to examine child and follow up
  - ✓ Observations/Consultations for Student Referrals: WPS, ESU#1, Mental Health
  - ✓ Share contact information with WCHS to facilitate obtaining health requirements

- **Consents are good for ONE school year.**

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** ____/____/____

Print Staff Signature: _____

Staff Signature: _____ **Date:** ____/____/____

Childs name: _____ **Birthdate**: _____

Date: _____

Source of Health and Emergency Care	Source of Health Care Coverage
PHYSICIAN:	INSURANCE:
CLINIC:	MEDICAID:
HOSPITAL ER:	Allergies:
DENTAL:	Conditions:
VISION:	Medication/Treatment:

KNOWN MEDICAL CONDITIONS:

_____
_____
_____

EMERGENCY ACTION PLAN:

_____
_____
_____

PARENT AND EMERGENCY CONTACT INFORMATION

1. _____Relationship_____

   Phone: _____or _____

2. _____Relationship_____

   Phone: _____or_____

3. _____Relationship_____

   Phone: _____or_____

CHILD'S NAME: _____ SEX:_____ DOB:_____

PERSON COMPLETING FORM: _____ DATE:_____

RELATIONSHIP TO CHILD: _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING DELIVERY?			
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3. WAS CHILD BORN OUTSIDE OF THE HOSPITAL?			
4. WAS THE CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5. WHAT WAS THE CHILD'S BIRTH WEIGHT?			_____lbs.,_____oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?			
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?			
8. DID CHILD OR MOTHER STAY IN THE HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9. IS MOTHER PREGNANT NOW?			IF YES, HAS PRENATAL CARE HAPPENED OR BEEN SCHEDULED?
HOSPITALIZATIONS AND ILLNESSES	**YES**	**NO**	**EXPLAIN "YES" ANSWERS**
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT (broken bones, head injuries, falls, burns, poisoning)?			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			
HEALTH PROBLEMS	**YES**	**NO**	**EXPLAIN (USE ADDITIONAL SHEETS IF NEEDED)**
13. DOES CHILD HAVE FREQUENT___SORE THROAT; ___COUGH;___URINARY INFECTIONS OR TROUBLE URINATING;___STOMACH PAIN,VOMITING, DIARRHEA?			
14. DOES CHILD HAVE DIFFICULTY SEEING? (SQUINT, CROSS EYES, LOOK CLOSELY AT BOOKS)?			
15. IS CHILD WEARING (or supposed to wear) GLASSES?			(if "yes") WAS LAST CHECKUP MORE THAN ONE YEAR AGO?
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING (pain in ear, frequent ear aches, discharge, rubbing or favoring one ear)?			
17. HAS CHILD EVER HAD CONVULSION OR SEIZURE IS CHILD TAKING MEDICINE FOR SEIZURES?			(if 'yes') ask WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE?_____
18. IS CHILD TAKING ANY OTHER MEDICINE NOW? (Special consent form must be signed for Head Start to administer any medication)			WHAT MEDICINE?_____ (if "yes") WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START?_____ HOW OFTEN?_____
19. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			PHYSICIANS NAME:_____
20. HAS CHILD HAD: ___BOILS ___CHICKEN POX ___ECZEMA ___GERMAN MEASLES ___MEASLES ___MUMPS ___SCARLET FEVER ___WHOOPING COUGH ___HIVES ___POLIO ___ASTHMA __BLEEDING TENDENCIES ___DIABETES ___EPILEPSY ___HEART/BLOOD VESSEL DISEASE ___LIVER DISEASE ___RHEUMATIC FEVER ___SICKLE CELL DISEASE			
21. DOES THE CHILD HAVE ANY ALLERGY PROBLEMS (rash, itching, swelling, difficulty breathing, sneezing)?			If Yes please explain:
22. (if any "yes" answers to questions 13-21) DO ANY OF THE CONDITIONS TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITES? DID A DOCTOR OR OTHEER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
23. ARE THERE ANY CONDITIONS WE HAVENT TALKED ABOUT THAT GET IN THE WAY OF THE CHILDS EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?

PHYSICAL,PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

24. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

25. DOES YOUR CHILD TAKE A NAP? __NO, __YES. IF "YES" DESCRIBE WHEN AND HOW LONG?

26. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? __NO__YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

27. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET?

28. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? ___YES___NO.
IF "YES" PLEASE DESCRIBE:

29. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

30. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?

31. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

32. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? ____NO ____YES. IF "YES' WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

33. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. HERE IS A LIST OF SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER.

		EARLIER	WHEN EXPECTED	LATER	AGE
a)	SIT UP WITHOUT HELP				
b)	CRAWL				
c)	WALK				
d)	TALK				
e)	FEED AND DRESS SELF				
f)	LEARN TO USE THE TOILET				
g)	RESPOND TO DIRECTIONS				
h)	PLAY WITH TOYS				
i)	USE CRAYONS				
j)	UNDERSTAND WHAT IS SAID TO HIM/HER				

34. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? ___NO ___YES. IF "YES" PLEASE DESCRIBE

35. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? ___NO, ___YES. IF "YES" EXPLAIN?

WHEN THIS HAPPENS WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

36. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? __NO, __YES. IF "YES" PLEASE DESCRIBE?

37. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? ___NO ___YES. IF "YES" PLEASE DESCRIBE.

38. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? __NO__YES. IF "YES" PLEASE DESCRIBE?