2017-2018 Program Year

_____
(Child's Name)

_____
(Unit)

Dear Parent/Guardian:

Head Start offers many medical related services; the services checked below are services you have chosen not to participate in.

___Immunizations
___Physical/Follow-up
___Lead Screening
___Dental/Follow-up

Please state reason for refusal _____
_____
_____
_____
_____
_____

I, as the parent or guardian, do release Head Start from any liability of physical and/or dental problems undetected due to my child's lack of participation in the physical, immunization, and/or dental services available through Head Start.

_____ _____
Parent/Guardian Signature Date

_____ _____
Health Coordinator Date

Cc: Child file/Health