Delay or Declination of Health Services

I, _____, parent/guardian of _____,
(Print Name) (Child's Name)

☐ Delay ☐ Decline

to have the below required screening completed on the enrolled Head Start/Early Head Start child named above. Head Start/Early Head Start has informed me of all the benefits of completing the following screening/follow-up and the possible medical/dental consequences of not completing it and I fully understand the information.

Please check the areas you are delaying and/or declining to complete on your child:

☐ Immunizations
☐ Physical
☐ Physical follow-up
☐ Vision recheck
☐ Hearing recheck
☐ Dental
☐ Dental follow-up treatment
☐ Hemoglobin
☐ Lead Testing

This Head Start/Early Head Start Program has offered information regarding financial assistance and community resources to me; to assist in having these identified needs met.

I **do not** wish to have this health and/or dental care needs met at this time because:

State reason(s)

I accept the consequences of this action and in no way hold this Head Start/Early Start Program or any staff responsible for any future health/medical/dental/developmental problems resulting from the lack of screening.

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff/Title Date

_____ _____
Health Coordinator Date