

**SEQUATCHIE VALLEY HEAD START  
MEDICAL/DENTAL CONSENT**

**PART 1 (for Head Start staff to fill out)**

\_\_\_\_\_ has an appointment with \_\_\_\_\_  
name of child name of health care provider  
for medical/dental care on \_\_\_\_\_ at \_\_\_\_\_.  
Appointment date time

The appointment is for this purpose: \_\_\_\_\_

Address and phone number of health care provider: \_\_\_\_\_  
\_\_\_\_\_

-----  
**Part II (to be filled out by parent/guardian)**

Please check A or B and sign & date below.

\_\_\_\_\_A. I give permission for my child to receive medical or dental care from the above named health care provider. I also consent for Sequatchie Valley Head Start to give the health care provider any medical or other necessary information in order to ensure continuity of health care. I also consent for Sequatchie Valley Head Start to obtain documentation of the results of the medical or dental care, and any recommendations, necessary treatment or follow-up from the exam.

\_\_\_\_\_B. I do not wish for my child to keep the above appointment for the following reason:  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

-----  
**Part III (to be filled out by parent/guardian)**

**TRANSPORTATION INFORMATION**

Please check A or B and sign & date below:

\_\_\_\_\_A. I will be able to provide transportation for my child to the above named appointment.

\_\_\_\_\_B. I will not be able to transport my child to the above named appointment. I give Sequatchie Valley Head Start permission to transport my child to the appointment.

**A PARENT OR GUARDIAN SHOULD GO WITH THE CHILD TO THE  
APPOINTMENT**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

**IMPORTANT**

If your child is unable to keep the appointment, please notify your family services worker at the Head Start center at least 24 hours prior to the appointment date, so it can be rescheduled.