

Mental Health Observation Form

Center: _____

Child: _____

I, _____, give my permission to
Parent/Guardian

the Mental Health provider, _____,
to observe my child in the Head Start Center.

The Mental Health Provider will have access to all screening, medical and LAP-D information. The center visit and observation will be discussed with the parent and staff. The records are confidential and will be kept in a locked cabinet.

Parent's Signature

Date

Head Start Representative

Date