CLASSROOM HEALTH SCREENING PERMISSION/RESULTS
PACT HEAD START

Child's ____B.D.___/___/___ Area # ____ Staff __________

Parent Name: ____

Mailing Address: ____________________________________/_________________/________/____________
City State Zip code

Dear Parent,
The local health department will be doing Vision and Hearing Screening at the Head Start classroom on ___________ with a rescreening date of ____________. In order for your child to participate, we need the following information and permission to release the information on this form to the health department:
Is your child on medical card? Yes No **Is your child on All Kids? Yes No**
If yes to either fill in recipient ID number ___ ___ ___ ___ ___ ___ ___ ___ ___
(9 digit # on back of Medi-plan card)
If no, your child will still receive the screening at no cost to you.

I give permission for the above information to be released to the health department, my child to participate in the screening, and for the health department to release the results of the screening to PACT.
I understand that I may revoke this authorization by giving written notice. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by the provider in reliance before I revoked it.
I understand that the information used or disclosed may be subject to re-disclosure by the agency receiving it and is no longer protected by the federal privacy regulations. However, PACT does not re-disclose information unless a written authorization requests it.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits from the provider releasing information (listed above).
I understand that this authorization is valid one year from the date signed, or until I revoke it in writing to the agency releasing information.

Parent/Authorized Agent signature ____ date _________________

Do not write below this line. **Return to teacher as soon as possible**
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DATE	VISION SCREENING RESULTS	DATE	HEARING SCREENING RESULTS
__/__/__	Passed	__/__/__	Passed
__/__/__	FAIL (1st screening, retest needed)	__/__/__	FAIL (1st screening, retest needed)
__/__/__	FAIL (2nd screening, needs referred)	__/__/__	FAIL (2nd screening, needs referred)
__/__/__	CNT (1st attempt) (cannot test)	__/__/__	CNT (1st attempt) (cannot test)
__/__/__	CNT (2nd attempt) (cannot test)	__/__/__	CNT (2nd attempt) (cannot test)

Comments: ____

Provider signature/agency ____Date of Screening__________

Provider signature/agency ____Date of Rescreen___________

After Screening: Email to Health Coordinator, Copy to Parent, Original to DCFS file, Family Advocates keep a copy of this form if rescreen is needed.