PARENT AUTHORIZATION for Health & Developmental Procedures
PACT for West Central Illinois

Child's Name _____ Area # _____

Several health and developmental procedures will be administered on children in the PACT Program. These may be completed by PACT staff, agreement with other agencies, or your own health care provider. Those completed through an agreement with other agencies (such as classroom dental exams and vision/hearing screenings) will have individual permission signed by the parent as they occur.

PACT will obtain results of screening completed by individual health provider by the parent submitting forms to PACT or by staff obtaining a specific release from the parent.

PACT staff has my permission to complete developmental screenings and vision/hearing screening on my child. PACT staff will explain all screenings and share the results with parent.

PACT will maintain a copy of results of health and developmental screenings for the purpose of: 1) identifying needed preventive and corrective care, 2) arranging for such care, and 3) providing an educational program suited to the individual child.

Parent/guardian signature _____ date _____